Acct #________

Saline Heart Group, P.A.

Health Questionnaire

Name:____ Birthdate:____________

Age:__________ Occupation:____

1. Do you have or have you every been diagnosed with:

Diabetes No_____ Yes_____ What year______

High Blood Pressure No_____ Yes_____ What year______

Heart Attack No_____ Yes_____ What year ______Hospital_________

Stroke No_____ Yes_____ What year______ Hospital_________

Rheumatic Fever No_____ Yes_____ What year______ Hospital_________

High Cholesterol No_____ Yes_____ What year ______Hospital_________

Angioplasty/Stent No_____ Yes_____ What year ______Hospital_________

Heart Cath/Dye Test No_____ Yes_____ What year ______Hospital_________

Heart Surgery No_____ Yes_____ What year ______Hospital_________

Pacemaker No_____ Yes_____ What year ______Hospital_________

Blood Transfusion No_____ Yes_____ What year ______Hospital_________

Hepatitis No_____ Yes_____ What year ______Hospital_________

2. List all surgical procedures and approximate dates:

Surgery	Date	Hospital

3. Have you ever smoked? No ___Yes ___How many years have you smoked?____

How many packs a day? ____ If you quit, what year did you quit?________

4. Do you drink alcohol No____ Yes____ How many years have you drank?____

How much per day?______________ If you quit, what your did you quit?______

5. Family History (blood relatives)

Father's age______ If deceased, age at death _____cause of death________________

Mother's age_____ If deceased, age at death _____cause of death________________

Have ANY blood relatives ever had any of the following:

Heart attack	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**
Bypass Surgery	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**
Heart Disease	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**
High Blood Pressure	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**
Diabetes	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**
Stroke/TIA	**No ____**	**Yes ____**	**Age occurred _____**	**Relation_______________**

6. Do you have any drug allergies: No ____Yes____ If yes, list the drug and reaction:

____

____

____

7. Are you allergic to iodine: No____ Yes _____

8. Do you take aspirin? No ____Yes____ If yes, what dosage? ________________

9. List all medications you are currently taking. Include dosage and frequency.
(Please bring your medicine in the bottles they were purchased in)

___________________________ ___________________________

___________________________ ___________________________

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Please answer the following questions. If you answer is yes, please explain

1. Do you have glaucoma, cataracts or thyroid disease? No_____ Yes_____

2. Do you have asthma, chronic bronchitis, pneumonia or tuberculosis? No_____ Yes_____

3. Do you have a history of heart disease? No_____ Yes_____

4. Do you have a history of ulcers, hernias or gastrointestinal bleeding? No_____ Yes_____

5. Do you have kidney problems? No_____ Yes _____

6. Do you have any unusual vaginal bleeding? No _____ Yes _____ N/A _____

7. Do you have prostate problems? No _____ Yes _____ N/A ______

8. Do you have arthritis? No _____ Yes _____

9. Do you have a skin condition or rash? No _____ Yes _____

10. Do you have a history of blood clots in your legs, veins or lungs? No_____ Yes _____