

# CARDIAC QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

|   |   |   |  |
|---|---|---|--|
| 1. Have you ever had any of the following?  |   |   |  |
| a. Episodes of passing out  | Y | N |  |
| b. Unusual shortness of breath  | Y | N |  |
| c. Unexplained fatigue  | Y | N |  |
| d. Frequent dizziness or lightheadedness  | Y | N |  |
| 2. Do you ever experience chest tightness, heaviness, pressure, or pain?  | Y | N |  |
| 3. Are you currently taking any of the following medications? (Please circle)   |   |   |  |
| a. <u>Anti-anginals</u> ? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)  | Y | N |  |
| b. <u>Calcium Channel Blockers</u> ? (Cardizem, Diltiazem, Isoptin, Calan, Verapamil, Nifedipine, Procardia, Adalat)  | Y | N |  |
| c. <u>Beta Blockers</u> ? (Corgard, Lopressor, Tenormin, Metoprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)  | Y | N |  |
| d. <u>Anti-arrhythmics</u> ? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiodarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)                   | Y | N |  |
| e. <u>Digitalis</u> ? (Lanoxin, Digoxin)  | Y | N |  |
| f. <u>Diuretics (water pills)</u> ? (Lasix, Oretic, Esidrex, Spironolactone, Aldactone)   | Y | N |  |
| g. <u>Anti-hypertensives (blood pressure pills)</u> ? (Aldomet, Captopril, Capoten, Apresoline, Minipress, Maxide, Dyazide, Vasotec, Minoxidil, Indapamide, Lozol, Methyl Dopa, Catapres) | Y | N |  |
| 4. Have you ever had palpitations, skipped beats, an irregular beat, or slow heart beat?  | Y | N |  |
| 5. Do you have a family history of cardiac sudden death? (brothers, sisters, parents, grandparents, children)   | Y | N |  |
| 6. Are you a heart patient currently under the care of a doctor?  | Y | N |  |
| 7. Do you have a history of rheumatic fever?  | Y | N |  |
| 8. Do you have mitral valve prolapse?   | Y | N |  |
| 9. Do you have a history of a heart murmur?   | Y | N |  |
| 10. Are you over 70?  | Y | N |  |
| 11. Do you have high blood pressure?  | Y | N |  |
| 12. Do you have a pacemaker? Type: _____ Rate: _____  | Y | N |  |
| 13. Have you ever had a MI (heart attack)? If so, when _____  | Y | N |  |
| 14. Do you have chronic lung disease, bronchitis, emphysema, wheezing, or asthma?   | Y | N |  |
| 15. Have you ever had heart surgery?  | Y | N |  |
| 16. Have you ever had an abnormal exercise test? (ie: Treadmill)  | Y | N |  |
| 17. Have you ever had an abnormal EKG?  | Y | N |  |
| 18. Do you have a history of any of the following?  |   |   |  |
| a. High cholesterol? Level _____  | Y | N |  |
| b. Smoking? How much per day? _____   | Y | N |  |
| c. Diabetes?  | Y | N |  |
| d. High blood pressure?   | Y | N |  |
| e. Family history of heart attacks?   | Y | N |  |
| f. Being more than 30 lbs. overweight?  | Y | N |  |