CARDIAC QUESTIONAIRE

Patient Name: ___________________________ Date: ______________

Question	Y	N
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. Anti-anginals? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)	Y	N
b. Calcium Channel Blockers? (Cardizem, Diltiazem, Isoptin, Calan, Verapamil, Nifedipine, Procardia, Adalat)	Y	N
c. Beta Blockers? (Corgard, Lopressor, Tenormin, Metaprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)	Y	N
d. Anti-arrhythmics? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiodarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)	Y	N
e. Digitalis? (Lanoxin, Digoxin)	Y	N
f. Diuretics (water pills)? (Lasix, Oretic, Esidrex, Spironolactone, Aldactone)	Y	N
g. Anti-hypertensives (blood pressure pills)? (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