DICRAN B. BARON, MD
CARDIOLOGY AND ARRHYTHMIA DISORDERS

NEW PATIENT HEALTH QUESTIONNAIRE

Name_____Sex_____Date_____

Address_____City/State_____Zip_____

Phone_____
(Work) (Home) (Cell)

Occupation _____ How long? _____
If retired please enter last occupation and how long retired

Birth Place _____Birth date _____Marital status_____

Insurance _____ Referring Physician_____

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INSTRUCTIONS: Please answer the following questions as best you can. If you are not sure how to answer a question, just put a question mark (?) beside it. This questionnaire is meant as an aide for the doctor to understand your medical history and how it may apply to your current problem. He will review your replies with you. Please be as thorough as possible.

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REASON FOR EVALUATION:

Briefly discuss the reason for this visit and evaluation:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS: List medications you now are taking:

Medication: Name Dose and How Often	Medication: Name Dose and How often

ALLERGIES: Please list any allergies or reactions to medications. Make sure to describe the reaction such as "rash, asthma, swelling, shortness of breath", etc. It is important to include any reactions to the following: Penicillins, Sulfa, other antibiotics, cardiac medications, aspirin.

Medication	Reaction	Medication	Reaction

PAST MEDICAL HISTORY:

Have you ever had any of the following problems or illnesses? If yes, check the disorder and write in approximate date (month/year).

- ❑ Rheumatic fever_____
- ❑ High blood pressure_____
- ❑ Heart attack _____
- ❑ Heart murmur _____
- ❑ High cholesterol_____
- ❑ Diabetes Mellitus_____
- ❑ Cancer or tumor_____
- ❑ Stomach/ulcer disease_____
- ❑ Asthma_____
- ❑ Emphysema _____
- ❑ Liver disease_____
- ❑ Pneumonia_____
- ❑ Tuberculosis_____
- ❑ Stroke Paralysis_____
- ❑ Gallbladder problems_____
- ❑ Kidney disease_____
- ❑ Bladder problems_____
- ❑ Cataracts or glaucoma_____
- ❑ Colon problems_____
- ❑ Arthritis_____
- ❑ Anemia_____
- ❑ Bleeding problem_____
- ❑ Thyroid disease_____
- ❑ Blood transfusion_____

Any other problems or comments:

_____
_____
_____
_____

HOSPITALIZATIONS AND OPERATIONS: List all major hospital stays and surgeries

Hospitalization/Reason	Date	Hospitalization/Reason	Date

MENSTRUAL HISTORY (females only):

Age when periods started: _____ Were/Are they regular? _____
Have you reached menopause? Yes❑ /No❑
Number of pregnancies: _____Miscarriages: _____ Children: _____
Were any pregnancies difficult? Yes❑ / No❑
During pregnancy did you have any of the following problems:
❑Heart problem, ❑high blood pressure, ❑kidney problem, or❑ diabetes?
If applicable what kind of birth control do you use? _____

HABITS:

Do you now smoke? Yes❑ / No❑ If yes, how long? _____ Yrs.
Did you smoke in the past? Yes❑/No❑ If yes, how long? _____ Yrs. Quit: _____years ago.

Type and amount of tobacco: ❑Cigarette_____packs/day ❑Cigar___/day ❑Pipe___x/day
❑chewing tobacco

Do you drink alcoholic beverages? Never❑ Rarely❑ Almost daily❑
What type of alcoholic drinks do you use frequently? _____
Do you drink caffeinated drinks often? Yes❑ / No❑

Do you follow a regular exercise program? Yes❑ / No❑
What kind of exercise do you do? _____
Do you feel stressed? Yes❑ / No❑Why? _____
Do you sleep well? Yes❑ / No❑ If not why? _____
Do you snore? Yes❑ / No❑

Are you on any special diet? (Please check if applicable)
❑Low salt_____ ❑Low cholesterol_____
❑Low sugar_____ ❑Vegetarian_____
❑Other_____

PLEASE FILL OUT COMPLETELY WITH CHILDREN AND GRANDPARENTS

FAMILY HEALTH HISTORY

Family		Age	Age at Death	Health Problems and Cause of Death			Age	Age at Death	Health Problems and Cause of Death
Father	X				Children	☐ M ☐ F			
Mother	X					☐ M ☐ F			
Brothers and Sisters	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				Grandparents (Mother's Side)				
	☐ M ☐ F				Male				
	☐ M ☐ F				Female				
	☐ M ☐ F				Grandparents (Father's Side)				
	☐ M ☐ F				Male				
	☐ M ☐ F				Female				

List any other significant family illness other than listed above in the table (please especially list any family member with hypertension, heart attacks, diabetes, strokes or cancer:

_____

_____

_____

MEDICAL HISTORY

Vital Statistics: Height: _____ Weight: _____

Do you now or in the past have any of the following problems? If yes, check the box and write in the approximate date (mo/yr) it started. If you are not certain the problem is significant, mark it with a question mark (?). The Doctor will review the responses with you. There is room for any comments below.

- ❑ Large weight gain
- ❑ Loss of weight
- ❑ Marked appetite loss
- ❑ Severe chronic fatigue
- ❑ Chronic fever or chills
- ❑ Excessive sweats
- ❑ Frequent/severe headaches
- ❑ Dizziness or imbalance
- ❑ Blockout or fainting spells
- ❑ Ear or hearing problems
- ❑ Eye or vision problems
- ❑ Frequent nosebleeds
- ❑ Frequent sore throat
- ❑ Pain or trouble swallowing
- ❑ Trouble with speech
- ❑ Hoarseness
- ❑ Poor teeth or gums
- ❑ Chronic cough
- ❑ Cough or vomit blood
- ❑ Pneumonia or pleurisy
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Awakening short of breath
- ❑ Short of breath walking
- ❑ Palpitations or irregular heartbeat
- ❑ Fast or rapid pulse
- ❑ Pain in arms or neck
- ❑ Frequent nausea or vomiting
- ❑ Heartburn
- ❑ Burning in stomach
- ❑ Abdominal pain, chronic
- ❑ Diarrhea, frequent
- ❑ Constipation, chronic
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Diverticulosis
- ❑ Bloody or black loose stools.
- ❑ Blood in the urine
- ❑ Kidney stones
- ❑ Trouble starting or stopping urine
- ❑ Pain urinating or passing water
- ❑ Frequent urination
- ❑ Urinated more than twice nightly
- ❑ Frequent urinary infections
- ❑ Dribbling or leaking or urine
- ❑ Prostate problems (males)
- ❑ Excessively bloody menses (females)
- ❑ Vaginal bleeding outside of periods (females)
- ❑ Sexual problems – Type?
- ❑ Chronic muscle aches or pains
- ❑ Tremor or hand shaking
- ❑ Bone, joint or other deformity
- ❑ Joint swelling
- ❑ Joint pains
- ❑ Frequent back pains
- ❑ Leg or ankle swelling
- ❑ Varicose veins or phlebitis
- ❑ Leg pain with walking
- ❑ Ulcers of the legs or feet
- ❑ Numbness or tingling sensations
- ❑ Weakness in hands, arms or legs
- ❑ Seizures or convulsions
- ❑ Hair gain or loss
- ❑ Chronic skin disease
- ❑ Lumps on your body
- ❑ Hay fever or hives
- ❑ Skin cancer – Where?
- ❑ Frequent depression
- ❑ Attempted suicide
- ❑ Difficulty with memory
- ❑ Blood disorder
- ❑ Alcoholism
- ❑ Narcotic or drug habit
- ❑ Yellow skin (jaundice)
- ❑ Easy bruising
- ❑ Difficult to stop bleeding
- ❑ Severe itching
- ❑ Cold when others are warm
- ❑ Hot when others are cold
- ❑ Thyroid problems
- ❑ Excessive thirst
- ❑ Are you happy with life?

COMMENTS:_____