Adult Congenital Heart Disease Clinic
New Patient Questionnaire

Today's Date: ___________________________

Patient's Name: ____

Age: __________________________ Referring provider: ______________________________________

What is the reason for your visit, and/or how can we best help you?

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Do you experience any of the following:

	NO	YES		NO	YES
Shortness of breath	☐	☐	Chest Pain	☐	☐
Depression/anxiety	☐	☐	Palpitations	☐	☐
Exercise intolerance	☐	☐	Dizziness/Lightheadedness	☐	☐
Abnormal fatigue	☐	☐	Fainting	☐	☐
Ankle swelling	☐	☐			

MEDICAL HISTORY:

Cardiac diagnosis (if known): ____

Previous cardiac procedures:
Please list procedure (catheterization, surgery, etc), where it was performed, and approximate date:

Procedure	Location/Institution	Date

Have you been hospitalized (other than the above)? ☐ No ☐ Yes

If yes, please explain (diagnosis, when, where):

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Name(s) and location(s) of previous cardiologist(s):

__________________________________ __________________________________

Do you have any other medical conditions?

Current medications, and reasons for taking:

Allergies to medications: ____________________________________

Have you been told to take antibiotics prior to dental care? ☐ No ☐ Yes

Have you been told to restrict your physical activity? ☐ No ☐ Yes

(Females only): Have you had any pregnancies? ☐ No ☐ Yes

FAMILY HISTORY:

Have your family members (siblings, parents, aunts, uncles, cousins, grandparents) had any of the following problems?

☐ Born with heart defect
☐ Sudden death at young age
☐ Heart rhythm abnormality
☐ Hypertension
☐ High cholesterol
☐ Fainting
☐ Heart attack *at age less than 55*
☐ Stroke *at age less than 55*
☐ Diabetes
☐ Asthma
☐ Other (explain):

SOCIAL HISTORY:

Occupation: ______________________________ Employer: ______________________

Highest level of education completed: ____________________________

Do you exercise regularly (type and frequency)?

Do you…	**NO**	**YES**	**Type, how much/how often**
drink alcohol ?.........	☐	☐	____________
use recreational drugs ?.........	☐	☐	____________
smoke/use tobacco?.........	☐	☐	____________
use caffeine (coffee, tea, soda, energy drinks, pills)?.........	☐	☐	____________
Does anyone at home smoke/use tobacco?.........	☐	☐	

REVIEW OF SYSTEMS:

Have you experienced any of the following **IN THE PAST MONTH:** (please explain any checked boxes below)

	None				
General:	☐	☐ Fatigue ☐ Weakness	☐ Weight loss	☐ Weight gain	☐ Fever
Skin:	☐	☐ Rash	☐ Color change		
Eyes:	☐	☐ Glasses	☐ Other vision problems		
ENT:	☐	☐ Ear infections ☐ Hoarseness	☐ Sinus infection ☐Bleeding gums	☐ Hearing problems ☐ Cavities or other dental problems	☐Nasal discharge ☐ Orthodontics
Sleep:	☐	☐ Snoring	☐ Daytime sleepiness	☐ Irregular breathing during sleep	☐Difficulty sleeping
Lungs:	☐	☐ Shortness of breath ☐ Other breathing difficulties	☐ Cough ☐ Wheezing	☐Pneumonia ☐ Noisy breathing	☐ Asthma ☐Coughing blood
Gastrointestinal:	☐	☐ Nausea ☐ Vomiting ☐ Constipation	☐ Abdominal swelling ☐ Bloody stools	☐ Diarrhea ☐ Black stools	☐ Abdominal pain ☐ Jaundice
Genitourinary:	☐	☐Frequent urination	☐Blood in urine	☐ Painful urination	
Menstrual:	☐	☐ First day of last period _________	☐ Irregularity	☐ Pain/cramping	
Musculoskeletal:	☐	☐ Scoliosis ☐ Joint pain	☐ Other spine problems	☐ Joint swelling	☐ Joint redness
Endocrine:	☐	☐ Heat/ cold intolerance	☐ Change in appetite	☐ Excessive thirst	
Hematologic:	☐	☐ Anemia ☐ Swollen glands	☐ Bruising	☐ Bleeding	☐ Blood clots
Neurologic:	☐	☐ Seizures ☐ Dizziness ☐ Paralysis	☐ Headaches ☐ Poor coordination ☐ Weakness	☐ Numbness ☐ Difficulty walking	☐ Tingling ☐ Difficulty speaking
Psychologic:	☐	☐ Depression ☐ Nightmares	☐ Anxiety ☐ Mood change	☐ Drug/ alcohol abuse ☐ Attention deficit	☐ Phobias ☐ Hyperactivity

Other concerns:

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