

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	