ARIZONA ARRHYTHMIA CONSULTANTS

Today's Date: _____

Health Questionnaire

Please check YES or NO if any symptoms are currently present
NOTE: Please do not leave any blanks

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cardiac:			**Respiratory:**			**Psychiatric:**		
Chest Pains			Snoring			Depression		
Palpitations			Hemoptysis (Coughing up blood)			Hallucinations		
Diaphoresis (Excessive sweating)			Dyspnea (shortness of breath)			**Hematologic:**		
Syncope (fainting)			**Gastrointestinal:**			Acute Anemia		
Orthopnea (Difficulty breathing laying down)			Nausea			Thrombocytopenia (low blood platelet count)		
PND (breathing disorder related to CHF)			Reflux			**Endocrine:**		
Vascular:			Bleeding			Goiter (enlarged thyroid)		
Claudication (Pain or limping in legs)			**Genitourinary:**			Tremors		
Edema or Swelling			Hematuria (Blood in urine)			**Derm:**		
Constitutional:			Frequent urination at night (>2 times/night)			Rash		
Weight gain			**Neurological:**			Skin Sores		
Weight loss			Dizziness			**Musculoskeletal:**		
Fever			Memory loss			Joint Pain		
HEENT: (Head, Ears, Nose & Throat)			Seizures			Myalgia (muscle pain)		
Visual Changes			**Reproductive:**					
Hearing loss			HX of oral contraception (Birth Control Pills)					

Preferred local pharmacy address and phone number:

_____

Preferred mail-order pharmacy address and phone number:

_____

Name: _____ **Date of Birth:** _____

Risks:

Diabetes (please circle): No Yes Juvenile onset Type 2 Adult onset
Hypertension (please circle): No Yes Year diagnosed: _____
Age >65 (please circle): No Yes
Dyslipidemia (abnormal cholesterol) (please circle): No Yes
--What type (please circle): Cholesterol Triglycerides Cholesterol & Triglycerides Low HDL Syndrome
Peripheral vascular disease (please circle): No Yes
Family History of premature coronary artery disease (Male or Female family members under 55 years of age) (please circle) : No Yes
Congestive Heart Failure (CHF) (please circle): No Yes
Have you been hospitalized for CHF (please circle): No Yes **If so, how often:**_____
History of Prior Stroke (please circle): No Yes

Social History:

FAMILY:

Please list any pertinent Family History: (please circle if applicable) ⬭ Adopted-Family History unknown

Father – Age: _____ Diseases: _____Deceased:
Mother – Age: _____Diseases: _____Deceased: _____
Brother/Sister – Age: _____ Diseases: _____Deceased:_____
Brother/Sister – Age: _____ Diseases: _____Deceased:_____
Child – Age: _____ Diseases: _____Deceased: _____
Child – Age: _____ Diseases: _____Deceased: _____

Marital Status (please circle): Married Single Divorced Separated Widowed Life Partner Significant Other
Children - How many: Sons:_____ Daughters: _____ None: _____

Tobacco usage:

Current: _____
Former: _____ Year quit: _____
Never: _____
Have you ever tried to quit?: _____

Type of tobacco use:

Chewing: _____ Units/Day: _____
Cigarettes: _____ Years used: _____
Pipe: _____
Passive smoke exposure?: _____

Activity (please circle): Moderate Sedentary Unable to exercise Vigorous

Type of exercise: _____ Frequency: _____

Alcohol:

Current: _____
Never: _____
Former_____

Frequency of alcohol use:

Daily: _____
Frequently: _____
Occasional/Social: _____

Caffeine (please circle): No Yes **Type of Caffeine use** (please circle): Chocolate Coffee Tea Soda Tablets Energy Drinks

Recreational Drug Use:

Current: _____
Never: _____
Former (year quit): _____

Type of recreational drug used:_____
Frequency: _____

Name: _____Date of Birth: _____

Social History Continued:

Race (please circle):

American Indian or Alaskan Native
Asian
Black or African American
Greek
Hawaiian
Hispanic or Latino
Indian
More than one race
Native American Indian
Other race
Unknown/Not reported
White

Ethnicity (please circle):

Hispanic or Latino
Not Hispanic or Latino

Primary Language (please circle):

English
French
German
Hebrew
Italian
Spanish
Vietnamese
Other

Occupation: _____ **Retired**: _____

List all medications you are currently taking: (Include over the counter & herbal supplements)

Name:	Dosage/Frequency:	Name:	Dosage/Frequency:
(None)			

List any Allergies (medication, Latex, Food, Inhalants or Chemicals)

(None)

List any previous surgeries/procedures including any previous cardiology surgeries/procedures

Type:	Date:	Type:	Date:
(None)			

List all past & current medical conditions

Type:	Date:	Type:	Date:
(None)			