Deborah Heart and Lung Center
200 Trenton Road, Browns Mills, NJ 08015-1799

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name: _____

REASON FOR VISIT: ☐ First time at Deborah as a patient ☐ Greater than 3 years since last patient visit

_____

_____

PAST MEDICAL HISTORY

Operations: _____

☐ Heart Surgery _____
☐ Lung Surgery _____
☐ Vascular Surgery _____
☐ Pacemaker _____
☐ Other _____

Medical Illness (within the last six months): _____

☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Diabetes _____
☐ Thyroid Problems _____
☐ Other _____

FAMILY HISTORY

Please give the following information about the health of your immediate family:

RELATION	AGE if alive	AGE at death	State of health or cause of death	RELATION	AGE if alive	AGE at death	State of health or cause of death
Mother				Spouse			
Father				Daughter(s)			
Sister(s)							
				Son(s)			
Brother(s)							

Have any blood relatives ever had any of the following?

"Heart Attack" _____ Blood disease _____ Cancer (specify type if known) _____
High blood pressure _____ Abnormal bleeding or clotting _____ Asthma _____
Diabetes _____ A disease which "runs in the family" _____ Any obscure or unusual disease _____
Heart Surgery _____ Kidney disease _____ Stroke _____

SOCIAL HISTORY

DO YOU SMOKE? ☐ no ☐ yes
How many per day _____ For how many years _____
What do you smoke? ☐ cigarettes ☐ pipe ☐ cigars
When did you quit smoking? _____ years ago.

OCCUPATIONAL HISTORY

List your past occupations, giving dates:

Occupation	From	To

ALCOHOL/BEVERAGES

Estimate the amount of alcohol you drink regularly:
_____ drinks* per day _____ drinks* per week
Did you formerly drink alcohol but have permanently stopped?
☐ no ☐ yes
Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day: _____ glasses, cups, or cans
*one drink = 1 can beer, 4oz. wine, or 1oz. hard liquor

PETS

Do you have pets at home? ☐ no ☐ yes
☐ dog ☐ cat ☐ bird ☐ other _____

GENERAL HEALTH AND HABITS

NUTRITIONAL ASSESSMENT

Your weight: 10 years ago _____ 5 years ago _____ now _____
Your appetite: ☐ excellent ☐ good ☐ fair ☐ poor
Are there foods you avoid (or limit) for health reasons?
Specify: _____
Food allergies/intolerance: ☐ no ☐ yes _____
Cultural/ethnic/religious preference: ☐ no ☐ yes

SPIRITUALITY ASSESSMENT

Support Systems: ☐ spouse ☐ significant other ☐ parent ☐ siblings ☐ children
Spiritual Beliefs: ☐ superior being/God ☐ none
Spiritual Practices: ☐ prayer ☐ meditation ☐ house of worship ☐ none

EXERCISE ASSESSMENT

Do you exercise regularly? ☐ no ☐ yes
How long have you exercised on a regular basis? _____ years
Type of exercise(s): _____
How often? _____ days/week _____ minutes each time

SLEEP ASSESSMENT

☐ no problem ☐ difficulty falling asleep
☐ insomnia ☐ awakens during night
☐ sleepwalks ☐ early morning awakening
☐ falls asleep immediately ☐ excessive snoring
☐ Hx sleep apnea

Trigger: _____

PATIENT REVIEW OF SYSTEMS

Answer all questions. If You do not know the answer or do not understand the question, insert a question mark. **LEAVE NO BLANKS!**

CIRCULATORY	NO	YES (date of onset)
Have you ever had any of the following:		
Chest pain	☐	☐ _____
Shortness of breath	☐	☐ _____
with exertion	☐	☐ _____
at rest	☐	☐ _____
awakening you from sleep	☐	☐ _____
sleeping propped up to breathe easier	☐	☐ _____
Palpitations	☐	☐ _____
Racing of heart	☐	☐ _____
Fainting spells	☐	☐ _____
Ankle swelling	☐	☐ _____
Pain/cramps/numbness in legs	☐	☐ _____
when walking	☐	☐ _____

Have you had any of the following tests:		(date of test)
Echocardiogram	☐	☐ _____
Cardiac catheterization	☐	☐ _____
Holter monitor	☐	☐ _____
Exercise test	☐	☐ _____
Nuclear stress, sestamibi or other	☐	☐ _____
Electrophysiology study	☐	☐ _____
Arterial doppler (carotids, abdomen, lower extremeties)	☐	☐ _____

Has a doctor ever told you you have:		
Angina	☐	☐ _____
Heart attack	☐	☐ _____
Heart failure	☐	☐ _____
Arrhythmia	☐	☐ _____
High blood pressure	☐	☐ _____
High blood cholesterol	☐	☐ _____
Rheumatic fever	☐	☐ _____

RESPIRATORY	NO	YES (date of onset)
Have you ever had any of the following:		
Pneumonia	☐	☐ _____
Frequent chest colds	☐	☐ _____
Pleurisy	☐	☐ _____
Tuberculosis skin test (pos or neg)	☐	☐ _____
Tuberculosis (infection or contact)	☐	☐ _____
Asthma (wheezing)	☐	☐ _____
Chronic bronchitis	☐	☐ _____
Cancer (lung)	☐	☐ _____
Emphysema	☐	☐ _____
Exposure to dangerous dust, chemicals, fumes, asbestos	☐	☐ _____
Trouble breathing	☐	☐ _____
Abnormal chest x-ray	☐	☐ _____
Have you ever coughed up blood?	☐	☐ _____
Do you often or regularly:		
Cough	☐	☐ _____
Raise septum	☐	☐ _____
Wheeze	☐	☐ _____

IMMUNIZATION HISTORY		
Flu	☐	☐ _____
Pneumonia	☐	☐ _____
Hepatitis	☐	☐ _____

ENDOCRINOLOGY		
Have you ever had any of the following:		
Hormone problems	☐	☐ _____
Thyroid disease	☐	☐ _____
Diabetes	☐	☐ _____
Osteoporosis	☐	☐ _____

Other _____

PATIENT REVIEW OF SYSTEMS *(continued)*

Answer all questions. If You do not know the answer or do not understand the question, insert a question mark. **LEAVE NO BLANKS!**

DIGESTIVE	**NO**	**YES** *(date of onset)*
Do you often or regularly have:		
Trouble swallowing	☐	☐ _____
Heartburn	☐	☐ _____
Abdominal pain	☐	☐ _____
Nausea	☐	☐ _____
Has there been any change in your bowel function in the last 6 months?	☐	☐ _____
Have you ever had any of the following:		
Hiatal or esophageal hernia	☐	☐ _____
Duodenal or gastric ulcer	☐	☐ _____
Liver trouble or hepatitis	☐	☐ _____
Gallbladder trouble or stones	☐	☐ _____

CUTANEOUS		
Have you ever had:		
Skin rashes	☐	☐ _____
Skin cancer	☐	☐ _____

BREAST DISEASE		
Have you ever had tumor(s), cyst(s), or any other breast disease?	☐	☐ _____

OBSTETRIC & GYNECOLOGICAL		
Menstruating:		
When was your last period?		_____
The one before?		_____
Regularity?		_____
Menopause	☐	☐ _____
When was your last period?		_____

NEUROLOGICAL		
Neurological disease	☐	☐ _____
Loss of consciousness	☐	☐ _____
Convulsions or seizures	☐	☐ _____
Head injury	☐	☐ _____
Stroke	☐	☐ _____
Paralysis or muscular weakness	☐	☐ _____
Double vision	☐	☐ _____
Loss of vision left right	☐	☐ _____

UROLOGY		
Kidney disease or nephritis	☐	☐ _____
Protein or albumin in urine	☐	☐ _____
Kidney stones	☐	☐ _____
Prostate trouble	☐	☐ _____
Urinary tract infection	☐	☐ _____
Do you have discomfort passing urine?	☐	☐ _____
How many times do you urinate at night?		_____
Are you on dialysis?	☐	☐ _____

JOINTS	**NO**	**YES** *(date of onset)*
Have you ever had any of the following:		
Muscle pain	☐	☐ _____
Back pain	☐	☐ _____
Joint pain	☐	☐ _____
Joint swelling	☐	☐ _____
Gout	☐	☐ _____
Has your doctor diagnosed arthritis, rheumatism?	☐	☐ _____

MOOD		
Have you recently:		
Experienced severe anxiety, panic or phobias	☐	☐ _____
Had a weight change or eating disorder	☐	☐ _____
Felt excessively fatigued	☐	☐ _____
Felt depressed	☐	☐ _____
Have you ever:		
Had a nervous breakdown	☐	☐ _____
Received psychiatric care	☐	☐ _____
Had a drug problem	☐	☐ _____

HEMATOLOGY & ONCOLOGY		
Have you ever had:		
Anemia	☐	☐ _____
AIDS	☐	☐ _____
Positive HIV test	☐	☐ _____
Bleeding or bruising tendency	☐	☐ _____
Cancer or tumor	☐	☐ _____
X-ray or radiation treatment	☐	☐ _____
Blood transfusion	☐	☐ _____

SPECIAL SENSES		
Have you ever had:		
Glaucoma	☐	☐ _____
Cataracts	☐	☐ _____
Other major eye disease	☐	☐ _____
Deafness	☐	☐ _____
Abnormal noises in the ear	☐	☐ _____

_____

Patient signature

PATIENT REVIEW ENDS HERE

FOR ADDITIONAL INFORMATION