THE HEART CENTRE

Patient Questionnaire

Patient Name: ..... **D.O.B.** .....
Address:.....
.....

Weight (kgs): ..... **Height (cms)**: .....

Circle either yes/no

Do you have heart problems? Yes No

Have you had a myocardial infarct or heart attack? Yes No

Have you been treated for hypertension or high blood pressure? Yes No

Have you had diabetes or increased blood sugar? Yes No

Do you have elevated cholesterol? Yes No

Do you smoke? Yes No

(For how long?.....How many per day?.....)

Have you had rheumatic fever? Yes No

Have you ever had a stroke? Yes No

Is there a family history of heart disease? Yes No

If yes, what was it?.....

Current Symptoms (in the past 3 months)

Have you had chest pain? Yes No

How often?.....For how long?.....

Do you do any regular exercise? Yes No

Do you experience any problems during exercise? Yes No

Do you get short of breath? Yes No

Do you get ankle swelling? Yes No

Have you had any tests for your heart? Yes No

Which tests & when?.....
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Heart Operations or procedures

Angiogram?	Yes	No
Angioplasty?	Yes	No
Coronary artery bypass graft (CABG)?	Yes	No
Heart valve surgery?	Yes	No
Pacemaker?	Yes	No

Medications-Please list what you take, how much and when:

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Other medical Problems/Allergies:

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