ELECTROPHYSIOLOGY ASSOCIATES, PA

Patient Medical History Questionnaire

Name: _____

Do you have any of these medical problems?

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Prior Heart Attack
- ❑ Stroke
- ❑ Angina (Chest Pain)
- ❑ Ulcer
- ❑ Bleeding Disorder
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Thyroid Disorder
- ❑ Cancer
- ❑ Lung Problems

Other: _____

Surgery

- ❑ CABG (Coronary Bypass)
- ❑ Valve Replacement
- ❑ Defibrillator
- ❑ Pacemaker
- ❑ Gall Bladder
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Hernia

Other: _____

Please list your Height: _____ Feet _____ Inches and your Weight: _____ Pounds

Drug allergies and reactions: _____

_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Have you smoked: ❑ No ❑ Yes Packs/Day____ # Years ____ If you quit, When?_____

Alcohol intake? ❑ No ❑ Yes Typical amount and frequency_____

Current or most recent occupation _____

Family History:

Father Alive, age _____ or Deceased at age_____ from: _____

Mother Alive, age _____ or Deceased at age_____ from: _____

# of Brothers and any illness _____

# of Sisters and any illness _____

and Ages of Children and any illnesses _____

Is there a family history of:

- ❑ Heart Attack
- ❑ Bypass Surgery
- ❑ Cardiac Arrest
- ❑ Serious Rhythm Problems
- ❑ Unexplained Fainting

Patient Medical History Questionnaire

Please Check all that Apply:

General
- ❑ Fevers
- ❑ Chills, Shakes
- ❑ Rashes
- ❑ Swollen Glands
- ❑ Frequent Itchiness
- ❑ Significant Intolerance to Heat or Cold

Eyes
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Cataracts
- ❑ Glaucoma

Ears
- ❑ Diminished Hearing
- ❑ Tinnitus (Ringing, Buzzing)
- ❑ Deafness

Mouth
- ❑ Poor Dentition
- ❑ Dentures
- ❑ Gum Bleeding

Cardiac
- ❑ Chest Pains
- ❑ Shortness of Breath
- ❑ Palpitations
- ❑ Dizzy Spells
- ❑ Fainting Spells
- ❑ Wake Up Gasping for Air

Lungs
- ❑ Cough
- ❑ Wheezing
- ❑ Pain with Deep Breathing
- ❑ Irregular Breathing during Sleep (Apnea)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Bright Blood in Stool
- ❑ Black / Very Dark Stool
- ❑ Poor Appetite
- ❑ Constipation
- ❑ Significant Weight Loss
- ❑ Acid Reflux

Neurologic
- ❑ Significant Memory Loss
- ❑ Arm or Leg Weakness
- ❑ Unsteady Gait (Walking)
- ❑ Speech Difficulty
- ❑ Visual Disturbances

Urologic
- ❑ Burning on Urination
- ❑ Blood in Urine
- ❑ Very Frequent Urination

Joints
- ❑ Swelling
- ❑ Stiffness
- ❑ Unusual Warmth

Mental Health
- ❑ History of Major Depression
- ❑ Severe Anxiety

Extremities
- ❑ Leg Pain while Walking
- ❑ Varicose Veins
- ❑ Swelling

Skin
- ❑ Rashes
- ❑ Bruises
- ❑ Moles