Patient Name:

DOB:

MR #:

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Date: _____

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

HEART AND VASCULAR NEW PATIENT QUESTIONNAIRE

Welcome to UW Health Heart and Vascular Care. Our goal is to provide complete care for your heart and blood vessels. Please assist us by filling out this form. The information provided will be a part of your permanent medical record and will be used to help us treat you. If you need help completing this form, please ask when you arrive to clinic.

Name: _____ Date of Visit: _____

Date of Birth: _____ Referring health care provider: _____

What is the purpose of today's visit? _____

CURRENT CARDIOVASCULAR SYMPTOMS		
Heart Arteries		
1. Do you ever have pain or discomfort in your chest?	☐ Yes	☐ No
If your answer is "No," please go to question 7.		
2. Does walking on a level surface at normal pace cause chest discomfort?	☐ Yes	☐ No
3. Do you get chest discomfort when you walk uphill?	☐ Yes	☐ No
4. Does it go away with rest?	☐ Yes	☐ No
5. How long does it take for the discomfort to go away? _____ minutes		
6. Does the discomfort begin when you are sitting or standing still?	☐ Yes	☐ No
Heart Muscle		
7. Do you get short of breath with activity?	☐ Yes	☐ No
8. Do you get short of breath when lying flat?	☐ Yes	☐ No
9. Do you wake up from sleep with shortness of breath?	☐ Yes	☐ No
10. Do you often have swelling in your legs?	☐ Yes	☐ No
Heart Rhythms		
11. Do you have heart palpitations or feel your heart race?	☐ Yes	☐ No
12. Have you ever had a slow heart rate?	☐ Yes	☐ No
13. Do you often feel dizzy or lightheaded?	☐ Yes	☐ No
14. Have you had a fainting episode?	☐ Yes	☐ No
Leg Arteries		
15. Do you have pain or discomfort in your legs when you walk?	☐ Yes	☐ No
If your answer is "No," please go to question 21.		
16. Does the discomfort begin when you are sitting or standing still?	☐ Yes	☐ No
17. Do you get discomfort with walking uphill or in a hurry?	☐ Yes	☐ No
18. Does walking on a level surface at a normal pace cause leg discomfort?	☐ Yes	☐ No
19. What happens to your leg discomfort if you stand still? ☐ It continues for more than 10 minutes ☐ It usually disappears in 10 minutes or less		
20. What part of your leg hurts when you walk? _____		
Brain Arteries		
21. Do you ever have sudden weakness on one side of your body?	☐ Yes	☐ No
22. Do you ever have numbness on one side of your body?	☐ Yes	☐ No
23. Do you ever have sudden loss of vision in one or both eyes?	☐ Yes	☐ No
24. Do you ever lose the ability to understand people?	☐ Yes	☐ No
25. Do you ever lose the ability to talk or write?	☐ Yes	☐ No

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Cardiovascular History (Check condition you have or had in the past, list details such as date and place)
☐ Heart Attack:
☐ Angioplasty or stent:
☐ Bypass surgery:
☐ Congestive heart failure:
☐ Atrial fibrillation:
☐ Pacemaker/defibrillator:
☐ Ablation procedure:
☐ Valve problems/surgery:
☐ Heart murmur:
☐ Leg artery blockage/amputation:
☐ Kidney artery blockage:
☐ Stroke, mini-stroke or TIA:
☐ Carotid artery surgery:
☐ Enlarged aorta/aneurysm:
☐ Other:

Risk Factors for Cardiovascular Diseases
(Check all that apply)

☐ High blood pressure Are you on medication for this problem? ☐ Yes ☐ No

☐ High blood sugar or diabetes Are you on medication for this problem? ☐ Yes ☐ No

☐ Cholesterol problems Are you on medication for this problem? ☐ Yes ☐ No

Please list your most recent values, if known: Total cholesterol _____

Triglycerides _____ HDL (good) cholesterol _____ LDL (bad) cholesterol _____

☐ Family history of cardiovascular disease

Heart disease (list person, age) _____

Sudden death (list person, age) _____

Stroke (list person, age) _____

High cholesterol (list person, age)_____

Diabetes (list person, age)_____

Tobacco Use. Please select the statement(s) that best describes you today:

☐ Never smoked tobacco regularly

☐ Remote smoking (quit smoking more than a year ago) What year did you quit? _____

☐ Recent smoking (quit smoking in last year) What date did you quit? _____

☐ Current Are you interested in quitting smoking? ☐ Yes ☐ No

How much do you smoke in an average day? _____

Do you live or work with a smoker? ☐ Yes ☐ No

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General Medical History (Check all that apply)		
☐ Asthma	☐ Anemia	☐ Thyroid problems
☐ Emphysema	☐ Blood clots	☐ Seizures
☐ Other lung disease	☐ Kidney disease	☐ Cancer or tumors
☐ Stomach ulcers	☐ HIV / AIDS	☐ Psychiatric illness
☐ Intestinal bleeding	☐ Arthritis	
☐ Liver disease	☐ Gout	

Please list any other medical problems or details you want us to know about:_____

_____

Social History

Are you ☐ Single ☐ Married / Partnered ☐ Divorced ☐ Widowed

If you have children, please list their ages:_____

What is your occupation? _____

What is the highest grade or level of school you completed? _____

Do you exercise regularly? ☐ Yes ☐ No
If "Yes," how often and what activities do you do? _____

If "No," what limits your level of physical activity? _____

What is your current weight? _____ pounds

What is a reasonable weight for you? _____ pounds

Would you like to lose weight? ☐ Yes ☐ No

Do you follow a special diet? ☐ Yes ☐ No If "Yes," please explain: _____

_____

How many servings of fruits and vegetables do you eat each day? _____ servings

How many times a week do you eat dessert? _____

How many drinks that contain alcohol (wine, beer, cocktails) do you have in an average week?
☐ 0 ☐ 0-4 ☐ 5-7 ☐ 8-14 ☐ 15 or more

Communication

What language do you speak at home? _____

Do you need an interpreter for this visit? ☐ Yes ☐ No

How do you learn best? ☐ Reading ☐ Listening ☐ Watching ☐ Other _____

Do you have a Power of Attorney? ☐ Yes ☐ No

Do you have a Living Will? ☐ Yes ☐ No

Do you have a Do Not Resuscitate order? ☐ Yes ☐ No
If "No," are you interested in learning about the above 3 items? ☐ Yes ☐ No

Please list the names of people with whom we have permission to discuss your medical condition:

_____

_____

_____

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Review of Systems (check symptoms you have had recently)		
General Problems	**Stomach or Intestine Problems**	**Muscle and Joints Problems**
☐ Recent weight changes	☐ Difficulty swallowing	☐ Muscle pain
☐ Severe fatigue	☐ Nausea or vomiting	☐ Muscle weakness
☐ Loss of appetite	☐ Heartburn or indigestion	☐ Joint pain
☐ Sleep problems	☐ Vomiting blood	☐ Back pain
☐ Fever or chills	☐ Dark or bloody stools	**Blood Disorders**
☐ Excessive sweating	☐ Stomach pain	☐ Easy bruising
☐ Skin rashes	☐ Constipation	☐ Easy bleeding
Head and Neck Problems	☐ Loose stools	☐ Anemia
☐ Headache	☐ Liver problems or jaundice	☐ Blood clots
☐ Vision problems	**Genital or Urination Problems**	**Gland / Hormone Problems**
☐ Hearing difficulties	☐ Frequent urination	☐ Thyroid disease
☐ Nasal Stuffiness	☐ Pain with urination	☐ Intolerance to cold
☐ Painful Teeth or Gums	☐ Difficulty with urination	☐ Intolerance to heat
Lung or Breathing Problems	☐ Blood in urine	☐ Frequent thirst
☐ Cough	☐ (Men) Problems with erections	☐ Hair loss
☐ Coughing or spitting up blood	☐ (Women) Hot flashes	**Psychiatric Problems**
☐ Mucus production	☐ (Women) I have gone through menopause	☐ Loss of interest
☐ Shortness of breath	**Vein Problems**	☐ Depression
☐ Wheezing	☐ Leg swelling	☐ Anxiety
☐ Snoring	☐ Varicose veins	☐ Panic
☐ Stopping breathing during sleep	☐ Leg cramps	☐ Stress
		☐ Loss of memory

Signature of Patient/Representative: _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: □ Minor □ Incompetent/Incapacitated
Legal Authority: □ Legal Guardian □ Parent of Minor
□ Health Care Agent □ Other _____

Reviewed by: _____ Date: _____ Time: _____