MRN

Name

BD Sex

University of Wisconsin Hospital and Clinics
600 Highland Avenue Madison, WI 53792

UW Health Heart and Vascular Care Clinic
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 call (608) 263-1530, or ask for assistance at the front desk.

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 laying 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___

Cardiovascular History
(check conditions 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 _____
Diabetes _____

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 ___

General Medical History (check all that apply)

___ Asthma
___ Emphysema
___ Other lung disease
___ Stomach ulcers
___ Intestinal bleeding
___ Liver disease
___ Anemia
___ Blood clots
___ Kidney disease
___ HIV/AIDS
___ Arthritis
___ Gout
___ Thyroid problems
___ Seizures
___ Cancer or tumors
___ Psychiatric illness

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 ___1-4 ___ 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, living will, or do not resuscitate order ? ___ Yes ___No

If no, are you interested in learning about them? ___ Yes ___No

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

_____

Review of Systems (check symptoms you have had recently)

General Problems
___ Recent weight changes
___ Severe fatigue
___ Loss of appetite
___ Sleep problems
___ Fever or chills
___ Excessive sweating
___ Skin rashes

Head and Neck Problems
___ Headache
___ Vision problems
___ Hearing difficulties
___ Nasal stuffiness
___ Painful teeth or gums

Lung or Breathing Problems
___ Cough
___ Coughing or spitting up blood
___ Mucus production
___ Shortness of breath
___ Wheezing
___ Snoring
___ Stopping breathing during sleep

Stomach or Intestine Problems
___ Difficulty swallowing
___ Nausea or vomiting
___ Heartburn or Indigestion
___ Vomiting blood
___ Dark or bloody stools
___ Stomach pain
___ Constipation
___ Loose stools
___ Liver problems or jaundice

Genital or Urination Problems
___ Frequent urination
___ Pain with urination
___ Difficulty with urination
___ Blood in urine
___ (Men) Problems with erections
___ (Women) Hot flashes
___ (Women) I have gone through menopause

Vein Problems
___ Leg swelling
___ Varicose veins
___ Leg cramps

Muscle and Joints Problems
___ Muscle pain
___ Muscle weakness
___ Joint pain
___ Back pain

Blood Disorders
___ Easy bruising
___ Easy bleeding
___ Anemia
___ Blood clots

Gland/Hormone Problems
___ Thyroid disease
___ Intolerance to cold
___ Intolerance to heat
___ Frequent thirst
___ Hair loss

Psychiatric Problems
___ Loss of interest
___ Depression
___ Anxiety
___ Panic
___ Stress
___ Loss of memory

Please list additional symptoms or conditions you would like us to know about

_____
_____
_____
_____
_____

Your signature: _____ _____ Date completed: _____

Health care provider signature: _____ Date and time: _____

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UW Health Heart and Vascular Care Clinic Medication History

Current Medications

Please list all medications, vitamins, and supplements that you take below. Please make sure your list is accurate and up to date. If you have an up to date and readable copy of your medication list, you may bring that with you instead of filling out this form.

Name of medication	Dose	When do you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

If you are taking more medicines, vitamins, or supplements, add the rest to the back of the page

Allergies or Medication Side-Effects (describe below)

Name of medication	What happened?	When?
1.		
2.		
3.		
4.		
5.		

If you have had trouble with more medicines, add the rest to the back of the page