Baylor Scott & White
DENTON HEART GROUP
A member of HealthTexas Provider Network

Patient Questionnaire

Thank you for coming to the Denton Heart Group. Please complete this questionnaire to the best of your ability.

NAME: _____ **DOB:** _____

Please indicate the reason(s) for your visit:

_____

Please indicate any prescriptions you need refilled:

_____

_____

Please indicate (check) any past medical history:

☐ **Diabetes**	☐ **High Blood Pressure**	☐ **High Cholesterol**
☐ Heart AttacK	☐ Congestive Heart Failure	☐ Irregular Heart Rhythm
☐ Emphysema	☐ Asthma	☐ Obstructive Sleep Apnea
☐ Stroke	☐ Seizures	☐ Gastric Reflux Disease
☐ Liver/Gallbladder	☐ Pancreas	☐ Kidney Disease
☐ Thyroid	☐ Cancer	☐ Anemia
☐ Blood Clots Leg or Lungs	☐ Arthritis	☐ Gout

Please indicate (check) any past surgical history:	**Year**
☐ Heart Bypass Surgery	
☐ Heart Valve Repair/Replaced	
☐ Abdominal Aortic Aneurysm Repair	
☐ Heart Cath (Angiogram)	
☐ EP Study/Ablation	
☐ Pacemaker or ICD	
☐ Leg Angioplasty/Stent	
☐ Stress Test	
☐ Echocardiogram/Ultrasound	
☐ Carotid Ultrasound	
☐ Holter Monitor or other heart rhythm monitoring device/patch	
☐ CT Scan	
☐ MRI	
☐ Calcium Score (EBCT)	
☐ Cholesterol or other labs	

Medications Currently Taking:

_____

_____

_____

_____

Please list any allergies and reactions:

Other physicians you are seeing:_____

_____

Please indicate (check) any past social history:

Marital Status: □ Married □ Separated □ Divorced □ Widowed □ Single

Exercise: □ No exercise □ 1 -3 times/week □ 4-6 times/week □ Daily

Tobacco (cigs, cigars, dips, snuff): □ Yes, Packs per day _____ □ No

Alcohol: □ None □ Socially □ Weekends only □ Daily □ Frequently

Illegal Drug Use: □ No □ Yes □ Used previously

Weight Loss Drugs: □ No □ Yes □ Used previously

OCCUPATION:_____

Please indicate (check) any past family history:

	Living	Age	Heart Attack / Bypass / Angioplasty / Stroke	Cholesterol/Diabetes/High Blood Pressure (circle)	Sudden Death
Father	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y
Mother	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y
Brother	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y
Sister	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y
Son	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y
Daughter	□ Y □ N		□ Heart Attack □ Angioplasty □ Bypass □ Stroke	□ Chol □ Diabetes □ HBP	□ Y

Is there any family history of **ABDOMINAL AORTIC ANEURYSM** (circle)? YES NO
If yes, please provide detail:_____

Patient Signature: _____Reviewed By:_____