Cardiovascular Consultants of Southern Delaware

New Patient Questionnaire

Date of Appointment: _______________

Patient Name: ____ Patient ID #: ______________________

Mailing Address: ____

Email Address: ____@__________________________________

BEST phone number to reach you: ___________________________________ Alternate: _________________________

Primary Care Physician (*include phone number if available*): ____

Referring Physician (*if different than Primary Care*): ____

Have you been seen by a Cardiologist in the past? If so, please provide name and phone number:

____

Reason for today's visit: ____

Please list ALL Allergies/Sensitivities with reactions: (*if additional room is needed, please use back of page*)

Drug	Reaction(s)

Local Pharmacy: _______________________________________ Mail in Pharmacy: __________________________________

Please list ALL Medications you are taking: (*if additional room is needed, please use back of page*)

Medication	Dosage	How many times per Day

Patient Name: ____ Patient ID #: ______________________

PAST MEDICAL HISTORY

Please list past medical Illnesses: ____

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Cardiovascular Illnesses: ____

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Please list past procedures/testing: (*if more room is needed, please use back of page*)

	Type	Date(s)	Location
Surgeries/Procedures (*non-Cardiac*)			
Cardiology Procedures (*Invasive*)			
Bypass Surgery			
Stent Placement			
Heart Cath			
Cardiology Procedures (non-*Invasive*)			
Stress Testing			
Echocardiogram (*ultrasound of heart*)			
Holter Monitor/Event Monitor			
Electrophysiology Procedures			
Device Implants			
Pacemaker or Defibrillator			
Peripheral Vascular Procedures			

Cardiac Risk Factor Screening	YES	NO	
Prior history of Heart Disease:			
Family history of Heart Disease:			
History of Hyperlipidemia (*high cholesterol*):			
Family history of Hyperlipidemia (*high cholesterol*):			
History of Hypertension (*High blood pressure*):			
Family history of Hypertension (*High blood pressure*):			
History of Diabetes Mellitus:			
Family history of Diabetes Mellitus:			

Patient Name: ____ Patient ID #: ______________________

Social History	YES	NO	
Alcohol Use			If yes, number of alcoholic drinks per day: __________ • Do you ever drink more: YES NO
Smoking/Tobacco Use	Current Number of packs/cigars per day ______	NEVER	OR Quit Date: ______________________
Caffeine Use			If yes, number of caffeinated drinks/day: ___________ • Do you ever drink more: YES NO If yes, number of decaffeinated drinks/day: ___________ • Do you ever drink more: YES NO
Exercise			If yes, how often: __________ times/daily __________ times/weekly Type of exercise: ____
Miscellaneous			
Race (*please circle one*)	American Indian or AK Native	Asian	Black or African American
		Native Hawaiian or Pacific Island	White
	Hispanic		Other (*please specify*): ____
Ethnicity (*please circle one*)	Hispanic or Latino	NON-Hispanic or Latino	
Preferred Language (*please circle one*)	English	Spanish	Other (*please specify*): ____
Marital Status (*please circle one*)	Single	Married	Widowed / Divorced

Please feel free to include any other information which may be pertinent to your care:
(*If additional room is needed, please use the back of the page*)

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