New Patient Questionnaire

Date of appointment (MM/DD/YYY):_____

Name (Last, First, MI):_____

Previous Names:_____

DOB (MM/DD/YYY):_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____

Email:_____

May we email you with sensitive information, such as test results? Yes No

If we call you, can we leave a voicemail with this information? Yes No

Preferred Pharmacy (name, address, phone):_____

_____

Primary Language spoken:_____

Would you be more comfortable with an interpreter at visits? Yes No

Primary Care Provider:_____

Clinic Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Current Cardiologist (or Referring Provider):_____

Clinic Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Other Specialists (Pulmonologist, Rheumatologist, Obstetrician, etc):

Name:_____Role (type of provider):_____

Clinic Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Name:_____Role (type of provider):_____

Clinic Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Use additional sheet of paper if needed.

Prior Locations (clinics or hospitals) where you have had **heart care**:

Dates of care (approximate):_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Dates of care (approximate):_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

Prior Locations (clinics or hospitals) where you have had **heart care** (cont'd):

Dates of care (approximate):_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____ Email:_____

EMERGENCY CONTACTS:

Emergency Contact #1:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____

Email:_____

Emergency Contact #2:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____

Email:_____

Use an additional sheet of paper if needed
PAST MEDICAL HISTORY:

HEART PROBLEM(S):

1._____

2._____

3._____

4._____

5._____

6._____

SURGERIES:

(list all surgeries, heart catheterizations, or heart rhythm procedures; include date & location):

1._____

2._____

3._____

4._____

5._____

6._____

If you have a pacemaker or defibrillator, list the date, type, settings (if known), & date of last check:

_____

_____

OTHER PAST MEDICAL HISTORY:

Have you ever been told you have any of the following health conditions?	Yes	No	Comments
Asthma			
COPD			
Pulmonary Hypertension			
Congestive Heart Failure			
Heart Attack			
High blood pressure			
Clotting disorder			
Kidney Disease			
Genetic Disorder/Syndrome			
Thyroid Disease			
Depression/Anxiety			
Sleep Apnea			
Cancer (please specify type)			
Other (please specify)			
Other (please specify)			
Other (please specify)			
Other (please specify)			

Use additional sheet of paper if needed.

FEMALES:

Are you currently pregnant? (circle one) Yes No Possible

Date of last period_____

Currently using birth control?_____ If yes, please list:_____

Have you ever been pregnant? (circle one) Yes No

If yes, how many times?_____ How many live births?_____

Any pregnancy complications? (circle one) Yes No

If yes, please describe:_____

VACCINATIONS: (circle one)

Have you had this year's flu vaccine? Yes No Date:_____

Have you had a pneumonia vaccine? Yes No Date:_____

Have you had a Tdap vaccine? Yes No Date:_____

FAMILY MEDICAL HISTORY:
(please list only biologic and immediate family history – parents, siblings, children):

Relationship: (father, mother, etc)	Medical Problem:	Living? Write Y or N (if No, age and reason for death)

Is there a history of congenital heart disease in *any* biologic family members? Yes No

If so, include above.

CURRENT MEDICATIONS:
(include prescription, over-the-counter, and herbal supplements):
If you have a typed list, please attach. Remember to bring all your medications in their original bottles to your appointment.

Medication Name	Dose/Strength	Times per day	For what condition?	Prescribed by?

If taking warfarin (Coumadin), who has been managing this?_____

ALLERGIES:
(medications, foods, latex, etc): None:_____
1._____ Type of reaction:_____
2._____ Type of reaction:_____
3._____ Type of reaction:_____

SOCIAL HISTORY:

Tobacco:
Do you currently smoke? (circle one) Yes No Quit

If yes, tobacco Type:_____

How many per day?_____ Number of years smoked:_____

If you previously quit, what year? And how did you quit?_____

Alcohol:
Do you currently drink on a regular basis? (circle one) Yes No

Type:_____ How much and how often?_____

Have you ever had a problem with alcohol? (circle one) Yes No

If so, did you quit or are you planning to? And how?_____

Drugs:
Do you use drugs? (circle one) Yes No Formerly

Type:_____Frequency:_____Route:_____Quit Date:_____

Type:_____Frequency:_____Route:_____Quit Date:_____

Type:_____Frequency:_____Route:_____Quit Date:_____

Type:_____Frequency:_____Route:_____Quit Date:_____

Have you sought treatment for drug abuse? (circle one) Yes No ____Outpatient ____Inpatient

Involved in 12 step or other program? (circle one) Yes No

Caffeine:
Do you drink caffeine regularly? (circle one) Yes No
Type:_____ _____

Amount per day:_____

Education/Employment/Military Experience:

Education:

_____Some high school
_____High school graduate
_____Some college
_____College graduate Degree obtained:_____
_____Post-graduate Degree obtained:_____

What do you do for work?_____

Have you been or are you currently exposed to occupational hazards? (circle one) Yes No

If so, please describe:_____

Military experience? Yes No Current branch:_____

Marital Status/Family/Support

Current status: _____Single
_____Married Do you have children? (circle one) Yes No
_____Divorced Number of children:_____
_____Widowed

With whom do you live?_____

Who provides you with emotional support?_____

Are you safe at home? (circle one) Yes No

Lifestyle:

How often do you exercise? (circle one) Never Occasionally Almost Every Day

Type of exercise:_____

How many days per week?_____

Hobbies/Activities?_____

Hours of sleep per night:_____

Changes in sleep lately? If so, why?_____

What do you wish you could do that you physically cannot do?_____

When was the last time that you could do that?_____

Mental Health: (circle one)

Do you have a history of depression, anxiety, or other mental illness?	Yes	No
If yes, have you ever needed counseling or used medications for mental illness?	Yes	No
Currently, have you felt sad or depressed for two weeks or more?	Yes	No
Currently, have you lost interest in enjoyable activities for two weeks or more?	Yes	No
If yes to any of the above, do you currently consider or have plans to harm yourself or another person?	Yes	No

Adult Congenital Heart Disease: (circle one)

Are you interested in meeting other adults with congenital heart defects?	Yes	No
Are you interested in teaching/counseling others with congenital heart defects?	Yes	No
If so, do you have experience in support groups or counseling?	Yes	No

If yes, please describe:_____

Have you heard of the Adult Congenital Heart Association (ACHA)?	Yes	No

If so:

Where did you hear about the ACHA?:

Have you attended an ACHA conference?	Yes	No

Where and when?:_____

Have you listened to an online ACHA webinar?	Yes	No

Which one(s)?: _____

Are you interested in local (in-person) patient education forums like the ACHA webinar?

If so, do you have any topics you'd like us to discuss?_____

We endorse the AÄÕÌÔ CÏÎÇÅÎÉÔÁÌ HÅÁÒÔ AÓÓÏÃÉÁÔÉÏÎ ¡ÁÃÈÁÈÅÁÒÔ®ÏÒÇ¢ and all that it has to offer to our patients.