Total Cardiology®
Your Heart. Your Health. For Life.

New Patient Clinic Questionnaire

(Please complete ONLY for your CLINIC VISIT – Not for Heart Tests)

To give you the most value for your time in our clinic we ask that you fill out this questionnaire before your appointment by answering each question to the best of your ability. This information is an important part of your medical record and will help us address your health issues more efficiently. **All information will remain strictly confidential.**

This, portion thereof or your other relevant additional medical information will become part of your medical file in paper and/or electronic format and may be shared and/or accessed via provincial Electronic Health Records (e.g. Alberta Netcare) to provide health care to you at different sites by different health care professionals♥.

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Maiden Name: _____

Date of birth *(Day / Month / Year)* _____ **Age** _____ **Gender:** ☐Male ☐Female

Mailing address: Street and Number _____

City: _____ Province: _____ Postal Code: _____

Phone numbers: Home (____) _____ Work (____) _____ Mobile (____)_____

Provincial Health Care Number: _____ **Province:** _____

Family Doctor's Name: _____

Referring Doctor's Name: _____ ☐ Check here if same as Family Doctor

E-mail address *(optional)*: _____;
(Communication currently only limited to appointment notices, surveys, and reminders)

Emergency Contact: Name: _____ Relationship: _____

Phone numbers: Home (____) _____ Work (____) _____ Mobile (____) _____

Cardiac concerns / Reason(s) for seeing a Cardiologist *(check ONLY those that apply to you)*:

Your Symptoms and Heart History:

- ☐ Chest pain /pressure /discomfort
- ☐ Shortness of breath
- ☐ Leg Swelling
- ☐ Dizziness /Presyncope
- ☐ Fainting /Loss of consciousness /Syncope
- ☐ Leg or calf pain /Claudication
- ☐ Palpitation /Awareness of your heart beat
- ☐ Fatigue

- ☐ History of Heart attack
- ☐ History of Heart failure
- ☐ History of Heart rhythm disorder
- ☐ History of Heart valve disease
- ☐ History of pericarditis or myocarditis

Your Cardiovascular Risk Factors:

- ☐ High Blood pressure (Hypertension)
- ☐ High Cholesterol (Dyslipidemia)
- ☐ Diabetes mellitus (Sugar disorder)
- ☐ Smoking
- ☐ Ex-smoker; Quit > 1 yr ago
- ☐ Obesity /Overweight
- ☐ Sedentary lifestyle /Little or no physical activity
- ☐ Family history of early heart disease /stroke
- ☐ Erectile dysfunction
- ☐ Kidney disease

Which of the following heart procedures have you had? *(check ONLY those that apply to you)*

Check here if NONE ☐

Procedure(s)	Date (if known)	City or Hospital	Procedure(s)	Date (if known)	City or Hospital
☐ Coronary angioplasty/stent			☐ Electrical cardioversion		
☐ Heart bypass surgery (CABG)			☐ Ablation-Radiofrequency		
☐ Heart valve surgery			☐ Heart Pacemaker		
☐ Heart valve implantation			☐ Internal cardioverter /defibrillator		
☐ Heart valve balloon procedure			☐ Heart Loop recorder		
☐ Congenital heart surgery			☐ Other: _____		
☐ Other: _____			☐ Other: _____		

Current Medications: (if you prefer please attach a legible and up-to-date list)

Include all prescription and nonprescription/over-the-counter medications you take on a regular basis (include vitamins, herbal supplements, etc.).

Check here if you are not taking any medications including over-the-counter and herbal ☐

Medication name	Dose	Frequency	Reason for taking this

Allergies and Intolerances: ***Check here if NONE*** ☐

Agent / Drug	Reaction Type	Comments

Are you allergic to shellfish? ☐ Yes ☐ No ☐ Unknown. If yes, indicate the type of reaction? _____
Are you allergic to x-ray dye? ☐ Yes ☐ No ☐ Unknown. If yes, indicate the type of reaction? _____

Medical History present or in the past *(check ONLY those that apply to you)*:
Check here if NONE ☐

☐ Cirrhosis of liver
☐ Irritable Bowel Syndrome
☐ Hiatal hernia
☐ Jaundice
☐ Reflux disease (gastroesophageal)
☐ Stomach or Duodenal ulcers
☐ Pancreatitis
☐ Crohn's disease
☐ Ulcerative colitis

☐ Arthritis/ joint disease
☐ Fibromyalgia syndrome
☐ Gout
☐ Lupus (SLE)
☐ Melanoma
☐ Osteoporosis
☐ Psoriasis
☐ Raynaud's disease
☐ Rheumatoid Arthritis
☐ Scleroderma
☐ Vasculitis

☐ Thyroid disorder/disease

☐ Asthma
☐ COPD/Emphysema ☐ Home O_2
☐ Pulmonary Embolism (blood clot)
☐ Pulmonary Hypertension
☐ Sleep apnea ☐use CPAP

☐ Rheumatic fever
☐ Rheumatic heart disease

☐ Bladder Cancer
☐ BPH (enlarged prostate)
☐ Prostate Cancer
☐ Prostatitis
☐ Kidney disease ☐On Dialysis

☐ Anemia
☐ Bleeding /Bruising disorder
☐ Lymphoma/Leukemia
(Blood disorders)

☐ Alzheimer's disease
☐ Dementia
☐ Migraine
☐ Multiple Sclerosis
☐ Neuropathy
☐ Parkinson's disease
☐ Seizures/Epilepsy
☐ Syncope (fainting)
☐ Stroke/TIA

☐ Aortic Aneurysm/Dissection
☐ Aortic dilatation
☐ Arteritis – artery inflammation
☐ Claudication
☐ Deep Venous Thrombosis (leg clot)
☐ Phlebitis /Thrombophlebitis
☐ Venous varices (Varicose veins)

☐ Trauma/Injury: _____

☐ Anorexia /Bulimia
☐ Anxiety & /or Panic disorder
☐ Bipolar disorder
☐ Depression
☐ Substance abuse
(e.g. Alcohol / Drugs)

☐ Cataract
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal detachment

☐ Breast lump (benign)
☐ Breast Cancer
☐ Cervical Cancer
☐ Ovarian Cancer

☐ Hepatitis: _____

☐ Endocarditis

☐ HIV infection

☐ Cancer; Type: _____

☐ Others: _____

Surgical History *(check ONLY those that apply to you)*: ***Check here if NONE*** ☐

☐ Appendectomy
☐ Cholecystectomy
(Gallbladder removal)
☐ Gastrointestinal surgery
☐ Hernia repair
☐ Hysterectomy
☐ D & C (cervix)

☐ Breast surgery
☐ Cataract surgery
☐ Retina surgery
☐ Ears / Nose / Throat surgery
☐ Tonsillectomy
☐ Thyroid surgery

☐ Lung surgery
☐ Brain surgery
☐ Back/Spine surgery
☐ Knee surgery
☐ Hip surgery
☐ Prostate surgery

☐ Bladder surgery
☐ Kidney surgery
☐ Vascular (e.g. AAA)
☐ Skin surgery

☐ Comments/Others: _____

Family History *(check ONLY those that apply to you)*: ***Check here if NONE or unknown*** ☐

Illness	Family member(s) affected	Living	Deceased
☐ Heart disease: Father/Brother @ < 55 years old		☐	☐
☐ Heart disease: Mother/Sister @ < 65 years old		☐	☐
☐ Stroke		☐	☐
☐ Fainting / Sudden loss of consciousness		☐	☐
☐ Sudden death		☐	☐
☐ Others: _____		☐	☐

Social History:

Country of birth: _____ **Language(s) spoken:** ☐ English ☐ French ☐ Other: _____

Ethnicity/Race (some heart diseases are present more commonly in certain ethnic groups):

☐ White/Caucasian	☐ Aboriginal	☐ Black	☐ South East Asian	☐ South Asian
☐ West Asian	☐ Arab	☐ Japanese	☐ Chinese	☐ Filipino
☐ Latin American	☐ Korean	☐ Other: _____		

Marital Status: ☐ Single ☐ Married ☐ Common law ☐ Separated or equivalent ☐ Divorced ☐ Widowed

Children's Ages: Daughters: _____ Sons: _____

Highest Level of Education (optional): ☐ High school or less ☐ College or University ☐ Other: _____

Occupational Status: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Retired ☐ Other: _____

Current or previous occupation: _____

Commercial Driver's License: ☐ Yes ☐ No **Pilot's License:** ☐ Yes ☐ No

Smoking ☐ Yes _____ Cigarettes/day ☐ No ☐ Quit; when: _____; ☐ failed to quit
☐ Yes _____ Cigars / Hookah ☐ No ☐ Quit; when: _____; ☐ failed to quit

Caffeine consumption ☐ Yes _____ Cups/day ☐ No

Energy drinks ☐ Yes _____ Drinks/day ☐ No ☐ Quit; when: _____; ☐ failed to quit

Alcohol consumption ☐ Yes _____ Drinks/day _____ Drinks/week ☐ No ☐ Quit; when: _____; ☐ failed to quit

Recreational / "street" drugs use ☐ Yes Type: _____ ☐ No ☐ Quit; when: _____; ☐ failed to quit

Exercise habits ☐ Yes _____ Minutes/day _____ Days/week ☐ No

Transfusions: If needed, will you accept transfusion of blood products? ☐ Yes ☐ No; why? _____

Females patients: ☐ Postmenopausal; Date of last menstrual period? _____
Currently pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Cultural, Spiritual or Religious beliefs: Do you have any issues that may affect your care or that you would like us to be aware of? ☐ Yes ☐ No; if yes please describe: _____

IMPORTANT: TotalCardiology's policy ensures uninterrupted cardiac care for you while protecting your medical information privacy. In the event that your cardiologist is unable or can no longer provide care for you, your medical records will be transferred to/assessed by another one of our cardiologists to maintain your continuity of care.

We sincerely appreciate your time completing this health questionnaire.

Signature: _____ Date: _____

♥ The personal health information that you provide to TotalCardiology is collected in paper and/or electronic formats, and is used and disclosed in accordance with the provisions of the *Health Information Act* (HIA) and any other applicable laws. This information will be used to provide diagnostic, treatment, and care services to you and to bill your Provincial Health Care or other third party payers for services provided. Any release of specific medical information to any third party can and will only be done with your explicit written consent and in accordance with the Provincial, The College of Physicians and Surgeons of Alberta, and TotalCardiology's policies and procedures for release of confidential information. You may withdraw your consent for release of such information at any time. For more information please contact us at 403-571-8600 and ask to speak with our privacy officer.