EXPERIENCE, INNOVATION & COMPASSION
SOUTHERN (SOUTH HILLS) PITTSBURGH AREA
Alan Bramowitz, MD | Peter M. Lemis, MD | Michael S. Nathanson, MD | Gennady Geskin, MD

New Patient Health Questionnaire **Date: ___/___/___**

Patient: ________________________ Gender: **M** **F**

Date of Birth: ___/___/___ Age:___ Occupation______________________

Referring Doctor:____

Reason for your visit: ____

Prior Heart Disease and Testing:

Heart murmur/Valve Prolapse….**NO YES**
Rheumatic/Scarlet Fever………. **NO YES**
Angina/Chest Pain…………….. **NO YES**
Heart Attack…………………… **NO YES**
Heart Cath/Angioplasty/Stent…. **NO YES**
Bypass Surgery…………………**NO YES**
Pacemaker……………………... **NO YES**
Defibrillator…………………… **NO YES**

Heart Failure………….**NO YES**
Stress Test…………….....**NO YES**
Echo/Ultrasound............**NO YES**
Calcium Scoring…........**NO YES**
Carotid Ultrasound……**NO YES**
CT Angiogram………...**NO YES**
Holter Monitor……….. **NO YES**
Nuclear PET scan……..**NO YES**

Risk Factors For Heart Disease:

High cholesterol……………….. **NO YES**
High blood pressure…………… **NO YES**
Numbness/Tingling of legs..….. **NO YES**
Female menopause……………. .**NO YES**
Stroke or TIA (ministroke)…….. **NO YES**
Current Smoker………………... **NO YES**
Previous Smoker……………… **NO YES** **Quit: Year:______**

Carotid Disease………. **NO YES**
Aortic aneurysm………. **NO YES**
Diabetes……………..…….**NO YES**
Leg Cramps walking...... **NO YES**
Venous (leg) clots…..... **NO YES**
Pulmonary embolism…. **NO YES**

Medications:
Please list all prescription and non-prescription medicines including vitamins and aspirin.

	Name	Dose/Strength	Frequency
1.	______	______	______
2.	______	______	______
3.	______	______	______
4.	______	______	______
5.	______	______	______
6.	______	______	______
7.	______	______	______
8.	______	______	______

DO YOU HAVE ANY ALLERGIES TO MEDICATION? **NO** **YES**
Please list all medications to which you have an allergy or adverse response and list the reaction.

	Medication	Reaction
1.	______	______
2.	______	______
3.	______	______
4.	______	______
5.	______	______

Do you have an allergy to IODINE, SHRIMP, or SHELLFISH?	**NO**	**YES**
Have you received X-ray contrast (IVP, myleogram, CT san)	**NO**	**YES**
If yes, did you have any reaction to the contrast?	**NO**	**YES**

FAMILY HISTORY
Please indicate with an **X** all those immediate family members with the following conditions.

	Father	Mother	Brother(s)	Sister(s)
1. Angina	______	______	______	______
2. Heart Attack	______	______	______	______
3. Angioplasty/Stent	______	______	______	______
4. Heart Bypass	______	______	______	______
5. Other Heart Surgery	______	______	______	______
6. Heart Failure	______	______	______	______
7. Stroke	______	______	______	______
8. Heart Valve Problem	______	______	______	______
9. Congenital Heart Disease	______	______	______	______
10. Hypertension	______	______	______	______
11. Abnormal Cholesterol	______	______	______	______
12. Diabetes	______	______	______	______
13. Abdominal Aortic Anuerysm	______	______	______	______
14. Pacemaker/AICD	______	______	______	______
15. Sudden Death	______	______	______	______

Father's age at death and cause, if deceased:_______________________________________
Mother's age at death and cause, if deceased:_______________________________________
Brother/Sister age at death and cause if deceased: __________________________________

Please list all past surgeries/hospitalizations and dates: ______________________________
____
____
____
____
Briefly describe any other past medical problems:___________________________________
____
____

Office Contacts and Locations:

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