The Heart Center
of Northeast Georgia Medical Center

Patient Consultation Questionnaire

Patient Name: ______________________________ Date: __________ Age: __________

Name of Doctor you are seeing today: ______________________________

Cardiologist Name: ______________________________ Primary Care Physician: ______________________________

Oncologist (if applicable): ______________________________

Have you had any of the following tests? If yes, please tell us where and when:

❏ Cardiac Catherterization – Where: ______________________________ When: __________

❏ Echocardiogram – Where: ______________________________ When: __________

❏ Chest X-ray – Where: ______________________________ When: __________

❏ CT Scan – Where: ______________________________ When: __________

Medical History: *(Check all that apply)*

❏ Rheumatic Fever	❏ Stomach Ulcers	❏ Emphysema	❏ Valve Infection
❏ Hepatitis	❏ Kidney Disorder	❏ Heart Attack	❏ Previous Blood Transfusion
❏ Liver Disorder	❏ Vascular Disease	❏ High Blood Pressure	❏ Blood Clots in your LEGS
❏ Varicose Veins	❏ Previous Heart Surgery	❏ High Cholesterol	❏ Sickle Cell Anemia
❏ Thyroid Disorder	❏ Stroke	❏ TIA	❏ Blood Clots in your LUNGS
❏ Dental Problems	❏ Diverticulitis	❏ Seizure Disorder	❏ Cancer

Allergies (list all): ______________________________

Previous Surgery: *(Please indicate the date if applicable)*

Tonsillectomy: ____________________ Gall bladder: ____________________

Prostate: ____________________ Brain: ____________________

Heart: ____________________ Appendectomy: ____________________

FEM POP: ____________________ Lung: ____________________

Kidney: ____________________ Carotid: ____________________

Are you on a blood thinner? ❏ Yes ❏ No If yes, indicate which one: ______________________________

Do you smoke? ❏ Yes ❏ No If quit, when? __________ If yes, how many packs per day? __________ How many years? __________

Do you drink alcohol? ❏ Yes ❏ No If yes, how much (Check ONE): ❏ Rarely ❏ Socially ❏ Frequently

Please list ALL Medications including the dose and frequency:

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________

______________________________ Dose: __________ Frequency: __________