Florida Heart & Lung Surgery

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HEALTH QUESTIONNAIRE

IDENTIFICATION DATA: Please print the following information.

Name_____ Date_____

Address_____ City_____ State_____ Zip Code_____

Date of Birth_____ Age:_____ Sex_____ Social Security #_____

Home Phone_____ Work Phone_____ Cell Phone _____

Current Marital Status_____ Email Address _____

Emergency Contact_____ Phone_____

HEALTH INSURANCE: Name of Insured_____

Policy #_____ ID # _____

Name of Provider _____

Address_____ City _____ State_____ Zip code _____

Secondary Insurance_____ Insured_____

Address of provider_____ City_____ State_____ Zip code_____

Policy #_____ ID # _____

REFERRING PHYSICIANS:_____ Specialty:_____

Address:_____ City_____ State_____ Zip code_____

Phone # _____ Fax # _____

PRIMARY CARE PHYSICIANS:_____ Specialty:_____

Address:_____ City_____ State_____ Zip code_____

Phone # _____ Fax # _____

ALLERGIES: (or "bad reactions" to any medications, food, or substances) Please list the allergy and reaction: Example: Peanuts / Reaction: Hives

_____ Reaction:_____

_____ Reaction:_____

_____ Reaction:_____

_____ Reaction:_____

PAST MEDICAL HISTORY: HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

☐ ANEMIA
☐ BLEEDING ABNORMALITIES
☐ BLOOD TRANSFUSION PROBLEM
☐ CANCER: TYPE _____
☐ CHRONIC LUNG DISEASE
☐ COLON PROBLEM
☐ CORONARY (HEART) ARTERY DISEASE
☐ DEEP VEIN THROMBOSIS (DVT)
☐ DIABETES: ☐ TYPE 1 ☐ TYPE 2
☐ HEART VALVE PROBLEM
☐ HEPATITIS ☐ TYPE A ☐ B ☐ C
☐ HERNIA:TYPE_____
☐ HIGH CHOLESTEROL
☐ HIV/AIDS
☐ HYPERTENSION
☐ IRREGULAR HEARTBEAT
☐ KIDNEY DISEASE
☐ PERIPHERAL VASCULAR DISEASE
☐ PULMONARY EMBOLISM
☐ STROKE
☐ THYROID DISEASE
☐ TUBERCULOSIS OR POSITIVE SKIN TEST
☐ ULCER: LOCATION_____

PAST SURGICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING SURGERIES?

☐ AORTIC ANEURYSM
☐ APPENDECTOMY
☐ BREAST SURGERY
☐ CAROTID ARTERY SURGERY
☐ COLON SURGERY
☐ GALL BLADDER
☐ HEART SURGERY
☐ HERNIA REPAIR: WHERE_____
☐ HYSTERECTOMY
☐ LEG ARTERY SURGERY
☐ LUNG SURGERY
☐ PROSTATE SURGERY
☐ TONSILLECTOMY
☐ THYROID SURGERY
☐ _____
☐ _____

☐ PREGNANCY: HOW MANY? _____
☐ OTHER SURGERY: WHAT?
_____

REVIEW OF SYSTEMS:

- ☐ WEIGHT GAIN/LOSS, TIREDNESS, OR WEAKNESS
- ☐ LYMPHATIC: SWELLING/TENDER NECK, GROIN OR UNDERARMS
- ☐ MUSCULOSKELETAL: PAIN, SORENESS, BLEEDING/WOUNDS/NUMB OR COLD FEET/HANDS
- ☐ ENT: PAIN OR SWELLING OF EARS, NOSE, MOUTH OR THROAT
- ☐ HEMATOPOIETIC: ANEMIA, BRUISING, CLOTTING, BONE MARROW DISEASE OR TRANSPLANT
- ☐ PSYCHOLOGICAL: ANXIETY, DEPRESSION, ANGER, NERVOUSNESS, HALLUCINATIONS
- ☐ ALLERGIES/IMMUNOLOGIC: HIV/AIDS, ASTHMA, HAY FEVER, OTHER REDUCED IMMUNITY
- ☐ RESPIRATORY: COUGHING, WHEEZING, INFECTIONS, SHORTNESS OF BREATH, COUGHING UP BLOOD, CHEST PAIN DIFFICULT BREATHING
- ☐ CARDIOVASCULAR DISEASE: LEG/ ANKLE SWELLING, FAINTING, IRREGULAR/FLUTTERING/OR POUNDING HEARTBEAT, PAIN WITH WALKING
- ☐ GI: ABDOMINAL, STOMACH, OR BOWEL PAIN/PROBLEMS, NAUSEA, VOMITING, DIARRHEA, OR CONSTIPATION
- ☐ GU: KIDNEY, BLADDER OR URINATION PROBLEMS (BURNING/STINGING, BLOOD IN URINE)
- ☐ NEUROLOGICAL: HEADACHES, DIZZINESS, HALLUCINATIONS, NUMBNESS OR DIFFICULTY SPEAKING
- ☐ NECK: SWELLING, PAIN, DIFFICULTY SWALLOWING, OR TINGLING
- ☐ SKIN: BRUISING, DISCOLORATION, RASHES, WOUNDS, PSORIASIS, DERMATITIS OR ECZEMA

Please explain any checked answers from above:

FAMILY MEDICAL HISTORY

HAVE ANY OF YOUR BLOOD RELATIVES (MOTHER, FATHER, BROTHERS, SISTERS, GRANDPARENTS, AUNTS, UNCLES) HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
☐ ANEMIA OR OTHER BLOOD DISORDERS	_____	☐ GLAUCOMA	_____
☐ ARTHRITIS	_____	☐ HEART DISEASE	_____
☐ ASTHMA	_____	☐ HIGH BLOOD PRESSURE	_____
☐ CANCER	_____	☐ HIGH BLOOD CHOLESTEROL	_____
☐ LUNG DISEASE	_____	☐ LIVER DISEASE	_____
☐ DIABETES (TYPE: _____)	_____	☐ NERVOUS SYSTEM	_____
☐ PERIPHERAL VASCULAR DISEASE	_____	☐ STROKE	_____
☐ EMPHYSEMA	_____	☐ THYROID DISORDER	_____
☐ OTHER	_____	☐ ULCER	_____
	_____	☐ AORTIC ANEURYSM	_____
	_____		
	_____		

SOCIAL HISTORY:

ALCOHOL DRINKS PER WEEK? 0____ (1-5) ____ (6-10) ____ (10+) ____

HAVE YOU EVER SMOKED? NEVER ____ YES_____ PACKS PER DAY____ ☐ QUIT SMOKING? WHEN? _____

SMOKING CESSATION: DISCUSSED WITH PATIENT ☐ YES ☐ NO TIME SPENT:_____

EMPLOYMENT:

Current Occupation:

_____

Other Jobs Performed:

_____

Hazardous Materials Exposure, including Asbestos:

_____

Medications: What medications do you currently take? List name, dosage, and how often you take it:

_____ Dosage_____ How often_____

_____ Dosage_____ How often_____

_____ Dosage_____ How often_____

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_____ Dosage_____ How often_____

_____ Dosage_____ How often_____

_____ Dosage_____ How often_____

_____ Dosage_____ How often_____

Please list any non-prescription medications or supplements that you take. Example would be aspirin, laxatives, vitamins, antacids, diet pills, herbs, etc. Please list absolutely everything you take.