Kailua Cardiology: Patient questionnaire

Personal History

Please check the boxes below if you have had any of the following symptoms or conditions in the last 30 days or in the past. *Check all that apply*.

Symptom or condition	Yes	NO	UNSURE
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Heart murmur or abnormal valve	☐	☐	☐
Chest pain	☐	☐	☐
Heart attack (MI)	☐	☐	☐
Irregular heartbeat	☐	☐	☐
Dizziness or fainting	☐	☐	☐
Stroke	☐	☐	☐
Shortness of breath	☐	☐	☐
Blood Clot in leg (DVT)	☐	☐	☐
Pulmonary embolism (PE)	☐	☐	☐
High cholesterol	☐	☐	☐
Diabetes	☐	☐	☐
Falls that caused injury	☐	☐	☐
Have you had any of the following tests or procedures:	**Yes**	**No**	**UNSURE**
Nuclear stress or treadmill test	☐	☐	☐
Cardiac catherization or angiogram	☐	☐	☐
Angioplasty or stent	☐	☐	☐
Heart surgery If YES, what kind? _____ Date of surgery: _____	☐	☐	☐

Medical details

Are you currently on blood thinners? (Xarelto, Warfarin, Eliquis) _____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

If so, with what company? (Boston Scientific, Medtronic, St. Jude, Biotronik) _____

Are you allergic to any of the following? ☐ Iodine ☐ Shellfish ☐ Contrast (Type of reaction) _____