patient Questionnaire

Toronto Cardiac Care

Please fill out this questionnaire before your appointment by answering each question to the best of your ability.
All information will remain strictly confidential.

First Name: _____ Last Name: _____

Preferred Name: _____ DOB (dd/mm/yyyy): _____ PHN: _____

Sex: ☐ Male ☐ Female ☐ Unknown/choose not to disclose Gender Identify: _____

Address (number and street): _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Family doctor's name: _____ Referring Doctor's Name: _____

Email address: _____
(Electronic communication currently limited to appointment notices, surveys, and reminders)

Emergency Contact Name: _____ Relationship to you: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Current Symptoms

In the past 6 months have you experienced any of the following:

Chest tightness, heaviness or pressure	☐ No	☐ Yes
Heart racing, pounding, irregular heartbeat	☐ No	☐ Yes
Fainting spells	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Breathing problems when lying down	☐ No	☐ Yes
Shortness of breath that awakens you but is relieved in upright position	☐ No	☐ Yes
Swelling in lower legs or feet	☐ No	☐ Yes

Cardiac History (check only those that apply to you)

Cardiovascular Risk Factors

- ☐ High blood pressure (hypertension)
- ☐ High cholesterol (dyslipidemia)
- ☐ Diabetes mellitus (blood sugar disorder)
- ☐ Obesity/overweight
- ☐ Sedentary lifestyle/little or no physical activity
- ☐ Family history of early heart disease/stroke
- ☐ Erectile dysfunction
- ☐ Kidney Disease

Heart History

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

Smoking Status

Do you smoke or did you quit less than one year ago? ☐ No ☐ Yes

If quit, approximately how long ago did you quit?
☐ <1 months ☐ 3-6 months ☐ 7-12 months
☐ 1-2 years ☐ 3-4 years ☐ 5+ years

Procedure History (check only those that apply to you):	Check here if no procedures ☐	
	Procedure(s)	**Approximate Date (if known)**
☐	Coronary angioplasty/stent	
☐	Heart bypass surgery (CABG)	
☐	Heart valve surgery	
☐	Heart valve implantation	
☐	Heart valve balloon procedure	
☐	Congenital heart surgery	
☐	Electrical cardioversion	
☐	Ablation-radiofrequency	
☐	Heart pacemaker	
☐	Internal cardioverter/defibrillator	
☐	Heart loop recorder	
☐	Other:	
☐	Other:	
☐	Other:	

Current Medications (You can also attach a legible, up-to-date list if you prefer)

Are you taking any prescription medications on a regular basis? ☐ No ☐ Yes Please list below:

Medication Name	Dose	Frequency	Reason for taking

Are you taking any non-prescription/over-the-counter medications on a regular basis? ☐ No ☐ Yes

Please list all non-Prescription/ over-the-counter medications below (includes vitamins and supplements):

Drug Allergies and Intolerances	Check here if none ☐	
Agent/Drug	**Reaction Type**	**Comments**

Are you allergic to shellfish? ☐ Yes ☐ No ☐ Unknown If yes, reaction: _____

Are you allergic to x-ray dye? ☐ Yes ☐ No ☐ Unknown If yes, reaction:

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		☐	☐
☐ Severe elevated cholesterol		☐	☐

Medical History (past or present – check only those that apply to you)

Check here if none ☐

Blood Disorders	☐ Anemia	☐ Bleeding/bruising disorder	☐ Lymphoma/leukemia
Cancers	☐ Breast lump	☐ Breast cancer	☐ Cervical cancers
	☐ Ovarian cancer	☐ Other cancer:	
Mental Health Disorders	☐ Anorexia/bulimia	☐ Anxiety/panic disorder	☐ Bipolar disorder
	☐ Depression	☐ Schizophrenia	☐ Substance Abuse
Eye Disorders	☐ Cataracts	☐ Glaucoma	☐ Macular Degeneration
	☐ Retinal detachment		
G (Stomach / Intestinal) Disorders	☐ Cirrhosis	☐ Irritable bowel syndrome	☐ Hiatal hernia
	☐ Jaundice	☐ Pancreatitis	☐ Crohn's disease
	☐ Ulcerative colitis	☐ Reflux disease (gastroesophageal)	
	☐ Hepatitis	☐ Stomach or duodenal ulcers	
Infections	☐ Endocarditis	☐ HIV	
Joint/Skin Disorders	☐ Fibromyalgia	☐ Arthritis/joint disease	☐ Gout
	☐ Lupus (SLE)	☐ Melanoma	☐ Osteoporosis
	☐ Psoriasis	☐ Raynaud's disease	☐ Rheumatoid arthritis
	☐ Scleroderma	☐ Vasculitis	
Kidney and Bladder Disorders	☐ Bladder cancer	☐ BPH (enlarged prostate)	☐ Prostate cancer
	☐ Prostatitis	☐ Kidney disease	On dialysis: ○ No ○ Yes
Central Nervous System Disorders	☐ Alzheimer's	☐ Dementia	☐ Migraine
	☐ Multiple sclerosis	☐ Neuropathy	☐ Parkinson's disease
	☐ Seizures/epilepsy	☐ Syncope (fainting)	☐ Stroke/TIA
Respiratory Disorders	☐ Asthma/COPD/emphysema (no home oxygen)		
	☐ Asthma/COPD/emphysema (with home oxygen)		
	☐ Pulmonary embolism (blood clots)		
	☐ Sleep apnea (no CPAP)	☐ Sleep apnea (with CPAP)	
Thyroid Disorders	☐ Hyperthyroidism	☐ Hypothyroidism	☐ Grave's
Vein/Artery Disorders	☐ Aortic aneurysm/ dissection	☐ Aortic dilatation	
	☐ Arteritis artery inflammation	☐ Claudication	
	☐ Deep venous thrombosis (leg clot)	☐ Phlebitis/thrombophlebitis	
	☐ Venous varices (varicose veins)		

Surgical History (check only those that apply to you)

Check here if none ☐

☐ Appendectomy	☐ Breast surgery	☐ Lung surgery	☐ Bladder surgery
☐ Cholecystectomy (Gallbladder removal)	☐ Cataract surgery	☐ Brain surgery	☐ Kidney surgery
	☐ Retina surgery	☐ Back/spine surgery	☐ Vascular surgery
☐ Gastrointestinal surgery	☐ Ear/Nose/Throat surgery	☐ Knee surgery	☐ Skin surgery
☐ Hernia repair	☐ Tonsillectomy	☐ Hip surgery	
☐ D+C (cervix)	☐ Thyroid surgery	☐ Prostate surgery	
☐ Others:			

Current Health Information

In the corresponding space below, please enter your latest heart rate and blood pressure reading as taken at home (write 'unknown' if unable to take heart rate or blood pressure at home):

Heart Rate: _____ Blood Pressure (e.g., 130/85) _____

Body Mass Index (BMI): This is a simple measure of body fat based on weight and height. To help us calculate your BMI, please enter your weight and height in the space below:

Height: _____ ☐ feet/in ☐ cm Weight: _____ ☐ pounds ☐ kg

Do you have private insurance for medications? ☐ Yes ☐ No Provider Name: _____

Do you use a specific pharmacy for medications? ☐ Yes ☐ No

- If yes, please list name and location: _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

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

Lifestyle/Behaviour	No	Yes	Amount per day		Quit Attempt		
					Yes	Quit Date	Failed to Quit
Alcohol	☐	☐		Drinks/day	☐		☐
				Drinks/week	☐		☐
Recreational/street drugs	☐	☐		Type	☐		☐

We appreciate you taking the time to complete this questionnaire.

Signature: _____ Date: _____

Toronto Cardiac Care ensure uninterrupted care for you while protecting your personal health information. In the event your cardiologist is unable to or can no longer provide care for you, your medical records will be transferred

*The personal health information that you provide to Toronto Cardiac Care 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 medial information to any third party can and will only be done with your explicit written consent and in accordance with Provincial, College of Physicians and Surgeons of Ontario and Toronto Cardiac Care's policies and procedures for release of confidential information. You may withdraw your consent for release of such information at any time.