Deborah®
Heart and Lung Center
200 Trenton Road, Browns Mills, NJ 08015

Name: _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

❑ First time at DEBORAH as a patient

❑ Greater than 3 years since last patient visit

REASON FOR VISIT:

_____

_____

PAST MEDICAL HISTORY

Operations: **Date:**

❑ Heart Surgery _____

❑ Lung Surgery _____

❑ Vascular Surgery _____

❑ Pacemaker _____

❑ Nose or Throat Surgery _____

❑ Tonsillectomy _____

❑ Other _____

Have you had any of the following tests?:
(Date of test)

❑ Echocardiogram _____

❑ Cardiac Catheterization _____

❑ Holter Monitor _____

❑ Exercise Test _____

❑ Nuclear Stress _____

❑ Electrophysiology Study _____

❑ Arterial Doppler _____

(carotids, abdomen, lower extremities)

❑ Pulmonary Function Testing _____

❑ CT Scans _____

❑ MRIs _____

❑ Chest X-rays _____

❑ Sleep Tests _____

Medical Illness	No	Yes (date)
Heart Attack	❑	❑ _____
Heart Failure	❑	❑ _____
High Blood Pressure	❑	❑ _____
High Cholesterol	❑	❑ _____
Diabetes	❑	❑ _____
Sleep Apnea	❑	❑ _____
Asthma	❑	❑ _____
Pneumonia	❑	❑ _____
Chronic Bronchitis	❑	❑ _____
Tuberculosis	❑	❑ _____
Cancer or Tumor	❑	❑ _____
Thyroid Problems	❑	❑ _____
Kidney Disease	❑	❑ _____
Anemia	❑	❑ _____
AIDS	❑	❑ _____
Positive HIV Test	❑	❑ _____
Blood Disorder	❑	❑ _____
Seizures	❑	❑ _____
Concussions (head Injury)	❑	❑ _____
Aortic Aneurysm	❑	❑ _____
Carotid Disease	❑	❑ _____
Deep Vein Thrombosis	❑	❑ _____
Peripheral Vascular Disease	❑	❑ _____
Stroke/TIA	❑	❑ _____
Varicose Veins	❑	❑ _____
Lymphedema	❑	❑ _____
Other	❑	❑ _____

FAMILY HISTORY

Please give the following information about the health of your immediate family:

RELATION	**Age if alive**	**Age at death**	State of health or cause of death	RELATION	**Age if alive**	**Age at death**	State of health or cause of death
Mother				Spouse			
Father				Daughter(s)			
Sister(s)							
				Son(s)			
Brother(s)							

SOCIAL HISTORY

DO YOU SMOKE? ❑ No ❑ Yes

How many per day_____For how many years _____

What do you smoke? ❑ Cigarettes ❑ Pipe ❑ Cigars

When did you quit smoking?_____years ago.

Any recreational drug use? _____

PETS

Do you have pets at home? ❑ No ❑ Yes

❑ Dog ❑ Cat ❑ Bird Other _____

ALCOHOL/CAFFEINE

Estimate the amount of alcohol you drink regularly:_____

_____*drinks per day _____drinks per week

*one drink = 1 can beer, 4 oz. wine, or 1 oz. hard liquor

Did you formerly drink alcohol but have permanently stopped?

❑ No ❑ Yes

Estimate the amount of caffeinated beverages (coffee, tea, cola) you drink per day _____ glasses, cups or cans.

OCCUPATIONAL HISTORY

List your past occupations, giving dates:

Occupation	From	To

GENERAL HEALTH AND HABITS

NUTRITIONAL ASSESSMENT:

Your weight: 10 years ago _____5 years ago_____now _____

Your appetite: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

SLEEP ASSESSMENT:

❑ No Problem ❑ Difficulty Falling Asleep

❑ Insomnia ❑ Awakens During Night

❑ Sleepwalks ❑ Early Morning Awakening

❑ Excessive Sleepiness ❑ Excessive Snoring

❑ Hx Sleep Apnea

Trigger: _____

EXERCISE ASSESSMENT:

Do you exercise regularly? ❑ No ❑ Yes

How long have you exercised on a regular basis? _____yrs.

Type of exercise(s): _____

How often? _____days/week _____minutes each time.

IMMUNIZATION HISTORY	**NO**	**YES (date)**
Flu	❑	❑ _____
Pneumonia	❑	❑ _____
Hepatitis	❑	❑ _____

PATIENT REVIEW OF SYSTEMS

Have you had any of the following recently:

CONSTITUTIONAL	**NO**	**YES** (date of onset)
Fatigue	❑	❑ _____
Frequent Falls	❑	❑ _____
Poor Appetite	❑	❑ _____
Weakness	❑	❑ _____
Weight Gain	❑	❑ _____
Weight Loss	❑	❑ _____
EYES		
Change in Vision	❑	❑ _____
Loss in Vision	❑	❑ _____
Irritation	❑	❑ _____
Dryness	❑	❑ _____
CARDIOVASCULAR (CIRCULATORY)	**NO**	**YES** (date of onset)
Chest Pain	❑	❑_____
at Rest	❑	❑_____
with Activity	❑	❑_____
Chest Discomfort	❑	❑_____
Radiating Jaw, Neck or Arm Pain	❑	❑_____
Trouble Breathing when Lying Flat	❑	❑_____
Swelling in the Lower Extremities	❑	❑_____
Lightheadedness	❑	❑_____
Fainting Spells	❑	❑_____
Palpitations	❑	❑_____
Rapid (racing) of the Heart	❑	❑_____
Passing Out	❑	❑_____
GASTROINTESTINAL		
Abdominal Pain	❑	❑_____
Bloating	❑	❑_____
Heartburn	❑	❑_____
Vomiting	❑	❑_____
Change in Your Stools	❑	❑_____
Black or Tarry Stools	❑	❑_____
Blood in Stools	❑	❑_____
Loss of Appetite	❑	❑_____
MUSCULOSKELETAL		
Abnormal Walking	❑	❑ _____
Joint Pain	❑	❑ _____
Joint Swelling	❑	❑ _____
Back Pain	❑	❑ _____
Deformity	❑	❑ _____
Muscle Weakness	❑	❑ _____
Muscle Cramps	❑	❑ _____
Numbness	❑	❑ _____
Tingling	❑	❑ _____

ENT (Ears, Nose, Throat)	**NO**	**YES** (date of onset)
Abnormal Hearing	❑	❑ _____
Poor Balance	❑	❑ _____
Dizziness	❑	❑ _____
Ear Pain	❑	❑ _____
Ringing in the Ears	❑	❑ _____
Headaches	❑	❑ _____
Nasal Congestion	❑	❑ _____
Neck Pain	❑	❑ _____
Difficulty Swallowing	❑	❑ _____
Sore Throat	❑	❑ _____
Dry Mouth	❑	❑ _____
Dripping in Back of Mouth	❑	❑ _____
RESPIRATORY	**NO**	**YES** (date of onset)
Chest Congestion	❑	❑ _____
Cough	❑	❑ _____
Shortness of Breath	❑	❑ _____
At Rest	❑	❑ _____
With Exertion	❑	❑ _____
During Sleep	❑	❑ _____
Wheezing	❑	❑ _____
Pleurisy	❑	❑ _____
Emphysema	❑	❑ _____
Excessive Phlegm Production	❑	❑ _____
Exposure to Dust	❑	❑ _____
Chemicals	❑	❑ _____
Fumes	❑	❑ _____
Asbestos	❑	❑ _____
Snoring	❑	❑ _____
Gasping During Sleep	❑	❑ _____
GENITOURINARY		
Difficulty Urinating	❑	❑ _____
Painful Urination	❑	❑ _____
Blood in Urine	❑	❑ _____
Urinary Incontinence	❑	❑ _____
Prostate Issues (Males)	❑	❑ _____
Bathroom Trips During Sleep	❑	❑ _____
SKIN		
Rash	❑	❑ _____
Jaundice	❑	❑ _____
Lesions	❑	❑ _____
Unusual Bruising	❑	❑ _____
Changes in Hair	❑	❑ _____

PATIENT REVIEW OF SYSTEMS *(continued…)*

NEUROLOGIC	NO	YES (date of onset)
Behavioral Changes	❑	❑ _____
Confusion	❑	❑ _____
Frequent Falls	❑	❑ _____
Dizziness	❑	❑ _____
Memory Loss	❑	❑ _____
Weakness	❑	❑ _____
Vertigo	❑	❑ _____
Fainting	❑	❑ _____
Restless Feeling in Legs	❑	❑ _____
Burning/Tingling/Numbness in Legs	❑	❑ _____

HEMATOLOGIC		
Easy Bleeding	❑	❑ _____
Easy Bruising	❑	❑ _____
Enlarged Lymph Nodes	❑	❑ _____

OBSTETRIC & GYNECOLOGICAL

Menstruating:

When was your last period? _____

The one before? _____

Regularity? ☐ No ☐ Yes

Menopause:

When was your last period? _____

PSYCHIATRIC	NO	YES (date of onset)
Anxiety	❑	❑ _____
Depression	❑	❑ _____
Irritability	❑	❑ _____
Mood Swings	❑	❑ _____
Panic attacks	❑	❑ _____
Trouble Concentrating	❑	❑ _____

ENDOCRINE		
Increased Thirst	❑	❑ _____
Increased Hunger	❑	❑ _____
Increased Urination	❑	❑ _____
Rapid, Pounding, or Irregular Heartbeat	❑	❑ _____
Flushing	❑	❑ _____
Cold Intolerance	❑	❑ _____
Hot Flashes	❑	❑ _____

ALLERGY/IMMUNOLOGY		
Seasonal Allergies	❑	❑ _____
Itchy Eyes	❑	❑ _____

Please bring the name and phone number of the pharmacy you use; and a list of medications (names and dose) and how you are taking them.

_____

Patient signature

Notes:

_____

_____

_____

_____

_____