

HEART DISEASE AND HYPERTENSION QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. APPLICANT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM/DD/YY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of first visit	Symptoms	
MM/DD/YY	Diagnosis	

Has the patient suffered any of the following symptoms? Yes No If "Yes", please explain.

Symptom		Date of first symptom	Severity	Frequency
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		
Loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY		

Has the patient undergone cardiovascular surgical intervention? Yes No If "Yes", please provide details.

Is the patient undergoing treatment? Yes No If "Yes", please provide details, name of medication and dosage.

Please provide the following information:

Date	MM/DD/YY	Height	<input type="checkbox"/> M <input type="checkbox"/> Ft	Weight	<input type="checkbox"/> Kg <input type="checkbox"/> Lb	Blood pressure
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Values of blood test results performed within the past 6 months:

Glucose		Glyco hemoglobin		Creatinine		Potassium		Sodium	
Total cholesterol		LDL		HDL		Triglycerides		Fundoscopy	

Specimen test results performed within the past 6 months:

Urine		Blood		Sugar		Albumin	
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Please enclose EKG and chest X-ray interpretations performed within the past 12 months. In case of mitral valve prolapsed or other valve disorders, please enclose results of echocardiogram.

EKG result		Date	MM/DD/YY
Chest X-ray result		Date	MM/DD/YY

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)			
Study		Date	Result
Echocardiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Stress test (treadmill)	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Myocardial scintigraphy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Creatinine clearance	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM / DD / YY	
History of smoking		Other comments	
Amount per day	Number of years		
Does the patient have any relatives that suffer or have suffered from cardiovascular disease or arteriosclerosis before the age of 55? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain.			
Are there any other relevant factors, diseases, symptoms, or complications not previously mentioned? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please explain.			
Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please the information requested below.			
Physician's name		Telephone	
Outpatient treatment			
Hospital		Telephone	
Hospital treatment			
3. TREATING PHYSICIAN'S INFORMATION			
Name			
Address			
Telephone		Fax	
Email			
Signature		Date	MM / DD / YY