# Northeast Georgia Physicians Group – Gainesville
# Cardiovascular & Thoracic Surgeons

## Patient Consultation Questionnaire

Patient Name: _____ Date: _____ Age:_____

Name of Doctor you are seeing today: _____

Cardiologist Name: _____ Primary Care Physician: _____

Oncologist (if applicable): _____

Have you had any of the following tests? If yes, please tell us **where** and **when**:

❑ Cardiac Catheterization – Where _____ When_____

❑ Echocardiogram – Where _____ When_____

❑ Chest X-ray – Where_____ When_____

❑ CT Scan – Where_____ When_____

**MEDICAL HISTORY:** *(Check all that apply)*

| | | | |
|---|---|---|---|
| ❑ Rheumatic Fever | ❑ Stomach Ulcers | ❑ Emphysema | ❑ Valve Infection |
| ❑ Hepatitis | ❑ Kidney Disorder | ❑ Heart Attack | ❑ Previous Blood Transfusion |
| ❑ Liver Disorder | ❑ Vascular Disease | ❑ High Blood Pressure | ❑ Blood Clots in your LEGS |
| ❑ Varicose Veins | ❑ Previous Heart Surgery | ❑ High Cholesterol | ❑ Sickle Cell Anemia |
| ❑ Thyroid Disorder | ❑ Stroke | ❑ TIA | ❑ Blood Clots in your LUNGS |
| ❑ Dental Problems | ❑ Diverticulitis | ❑ Seizure Disorder | ❑ Cancer |

Allergies (list all): _____

**PREVIOUS SURGERY:** *(Please indicate the date if applicable)*

Tonsillectomy:_____ Gallbladder: _____

Prostate:_____ Brain: _____

Heart: _____ Appendectomy: _____

FEM POP: _____ Lung: _____

Kidney: _____ Carotid:_____

Are you on a blood thinner? ❑ Yes ❑ No If yes, indicate which one_____

Do you smoke? ❑ Yes ❑ No If quit, when? _____ If yes, how many packs per day? _____ How many years? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much (Check ONE): ❑ Rarely ❑ Socially ❑ Frequently

**Please list ALL Medications including the dose and frequency:**

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

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