Groupe Cardiologique
ETTELBRUCK

_____
Patient name

QUESTIONNAIRE FOR PATIENTS:

Please tick as appropriate and/or fill in the blanks. Please be as accurate as you can with respect to timing.

1. **Current symptoms/problems** Please specify the reason for your visit to the doctor.

a) *Type of symptoms*

◯ Chest pain ◯ Shortness of breath ◯ Palpitations/tachycardia ◯ Profuse sweating
◯ Leg swelling ◯ Fast exhaustibility ◯ Weight gain ◯ Weight loss
◯ Fatigue during the day ◯ Snoring/breathing pauses ◯ Cough/sputum ◯ Fever/chills
◯ Other:

b) *How long have you been experiencing these symptoms?*

◯ For ___ days ◯ For ___ weeks ◯ For ___ months ◯ For ___ years

c) *What triggers these symptoms?*

◯ Physical exertion ◯ Physical rest ◯ Sleep ◯ Cold
◯ Stress, excitement, fear ◯ Other: ◯ I don't know

d) *How long do these symptoms last?*

◯ ___ seconds ◯ ___ minutes ◯ ___ hours ◯ ___ day(s) ◯ Constantly present

2. Medical history of heart and vessels Which health problems have you had/do you have?

◯ Heart attack _____ ◯ Coronary stent/dilation _____
◯ Heart bypass surgery _____ ◯ Other operation on the heart or aorta _____
◯ Dilation of the aorta ◯ In the chest _____ ◯ Circulatory disorders of the legs _____
◯ In the abdominal area_____ ◯ Hypertension since _____
◯ Deep vein thrombosis/pulmonary embolism _____ Date and place of last coronarography: _____
◯ Stroke/circulatory disorder of the brain _____ ◯ Other _____

3. **Risk factors** What applies to you?

◯ Diabetes since _____ ◯ Insulin since _____ ◯ Increased blood lipids/cholesterol _____
◯ Kidney weakness/elevated kidney values _____ ◯ Elevated uric acid/ ◯ Gout _____
◯ Sleep apnoea/nocturnal ventilator _____ ◯ Heart/circulatory disorders in the family _____
◯ Sudden deaths in younger family members Height _____ cm Weight _____ kg

3. Pre-existing conditions/operations/procedures/injuries Please list other diseases as precisely as possible!

◯ Head/brain _____ ◯ Neck/thyroid _____
◯ Chest/mammary glands _____ ◯ Lung/bronchial tubes _____
◯ Small intestine/colon _____ ◯ Oesophagus/stomach _____
◯ Kidneys _____ ◯ Liver/gall bladder/spleen _____
◯ Spine _____ ◯ Arteries/veins _____
◯ Bones/joints _____ ◯ Skin _____
◯ Other _____ ◯ Blood/lymphatic system _____

4. **Allergies/intolerance** Please indicate important sensitivities for medical treatment.

◯ Iodine _____ ◯ X-ray contrast agent _____
◯ Penicillin _____ ◯ Other: _____

5. **Alcohol and tobacco/drugs** Please specify your habits as closely as possible.

Smoking: ◯ Non-smoker ◯ Ex-smoker since _____ ◯ Smoker, _____ pack(s) per day for _____ years
Alcohol: ___ glasses/bottles of wine/beer/spirits per week ◯ Complete abstinence from alcohol since _____
Other:_____

Please turn over

6. **Daily activity** Please rate your average daily physical activity.

a) Night-time sleep _____hours
b) Low physical activity _____hours
c) Moderate physical activity _____hours
d) Intense physical activity _____ hours
e) Walking distance from home _____km per day ____ times per week

7. **Sports** Please indicate any sport activity that you perform in addition to everyday activity.

◯ Non-athletic ◯ No sport for _____ years Previous sports: _____
◯ Athletic, _____hours of sport per week
Current athletic activities: _____

8. **Profession** Please specify your current profession and activities that you have practised for many years or recently.

_____
_____

9. **Medication** Please specify **all** medications that you are currently taking or have recently taken – even those that are not for the heart. If available, please provide a copy of all medications that you are taking.

Medication	Strength	Administration				
		Morning	Noon	Afternoon	Evening	Night
Medication XY	*100mg*	*1*	*0*	*0*	*1*	*0*