A department of Ka'u Hospital
East Hawaii Health Clinic
1190 Waianuenue
Cardiology

Patient Name: ___________________________ Birthdate: ___________

SUPPLEMENTAL MEDICAL QUESTIONAIRE

Medical History: *(Please select all that apply and specify any other medical conditions)*

- ☐ Atrial Fibrillation
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Heart Attack
- ☐ Congenital Heart Disorder
- ☐ Asthma
- ☐ Sleep Apnea
  Use of [ ] CPAP [ ] BiPAP
- ☐ Gastro Esophageal Reflux Disease (Acid Reflux)
- ☐ Arthritis
- ☐ Diabetes Mellitus
  [ ] Type 1 [ ] Type 2
  Controlled with [ ] Pills [ ] Insulin
- ☐ Stroke
- ☐ Fibromyalgia
- ☐ Anxiety
- ☐ Depression
- ☐ Chronic Kidney Disease
- ☐ COPD / Emphysema (Chronic Obstructive Pulmonary Disease)
- ☐ History of Heart Failure
- ☐ Cirrhosis of Liver
- ☐ History of Stomach Ulcer
- ☐ Osteoporosis
- ☐ History of Kidney Stone(s)
- ☐ Cancer
  Type: ________________________
  Treatment: ___________________
- ☐ AIDS
- ☐ History of DVT (Deep Vein Thrombosis)
- ☐ Systemic Lupus Erythematosus
- ☐ Menopause
  Type: [ ] Natural [ ] Surgical
- ☐ History of Substance Abuse
  Quit Date: ____________________
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ History of Rheumatic Fever
- ☐ Vascular (vein) Disease
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Neuropathy
- ☐ Seizure
- ☐ Bipolar Disorder
- ☐ Anemia
- ☐ End Stage Renal Disease
  Dialysis Frequency: _____________
- ☐ Enlarged Prostate / BPH
- ☐ Gout
  Last Episode Needing Prescription:
  ____
- ☐ History of Sudden death in mother, father, sister or brother <65 years of age
  ____
  ____
- ☐ HIV Posit
- ☐ HIV Positive
- ☐ History of PE (Pulmonary Embolism)
- ☐ Complication with Anesthesia
- ☐ History of Alcoholism
  Quit Date: ____________________
- ☐ Blood Coagulation Disorder
- ☐ Gestational History:
  [ ] Hypertension [ ] Diabetes
  [ ] Preeclampsia or Preterm labor < 37 weeks

Social History: *(Please select all that apply)*

Marital Status:
[ ] Single [ ] Married [ ] Divorced
[ ] Legally Separated [ ] Widow / Widower
[ ] Life Partner [ ] Civil Union
[ ] Common Law Marriage [ ] Unknown

Children: Number of Children: __________

Who you live with:
[ ] Spouse [ ] Significant Other
[ ] Children [ ] Family [ ] Caregiver
[ ] Adopted Family [ ] Foster Family
[ ] Friend(s) [ ] Animals [ ] No Animals
[ ] None

Domestic Violence:
[ ] Yes [ ] No

Do you feel safe at home?
[ ] Yes [ ] No

Recently felt controlled, threatened, or were physically hurt:
[ ] Yes [ ] No

Alcohol Use: [ ] Yes [ ] No
Former Use: [ ] Yes [ ] No
Quit: __________________________________

Frequency:
[ ] Do not drink
[ ] 0-2 drinks per day
[ ] 2+ drinks per day
[ ] A few times a week
[ ] A few times a month
[ ] Occasionally
[ ] Other

Smoking Status:
Do you smoke? [ ] Yes **or** [ ] No

Physical Activity:
[ ] Walking [ ] Running [ ] Bicycling
[ ] Swimming [ ] Yoga [ ] Aerobics
[ ] Weight Training
[ ] Other: ___________________________

Frequency:
[ ] 1-2 Times per wk [ ] 3-4 Times per wk
[ ] 5-6 Times per wk [ ] Daily
[ ] Other: ___________________________

Duration:
[ ] < 15 min per day [ ] 15-30 min per day
[ ] 30-45 min per day [ ] 45-60 min per day
[ ] 60-90 min per day [ ] > 90 min per day
Other: _______________________________

Official use only: MRN#: _________________________ Account #: ____________________

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SUPPLEMENTAL MEDICAL QUESTIONAIRE

Surgical History: *(Please select all that apply)*

- ☐ Abdominal Aortic Aneurysm (AAA) Repair
- ☐ Amputation
- ☐ Appendix Removal
- ☐ AV Fistula Shunt
  - [ ] Left [ ] Right
- ☐ Back Surgery
- ☐ CABG/Heart Bypass Surgery:
  - [ ] x1 [ ] x2 [ ] x3 [ ] x4 [ ] x5 [ ] x6 [ ] x7
- ☐ Cardiac Ablation
- ☐ Cardiac Stent
  - How Many: _______________
- ☐ Cardioversion
- ☐ Carotid Endarterectomy
- ☐ Cataract
  - [ ] Left [ ] Right [ ] Both
- ☐ Colon Surgery
- ☐ Coronary Angioplasty
- ☐ Defibrillator
  - Brand: _______________
- ☐ Gall Bladder Surgery
- ☐ Heart Catheterization
- ☐ Heart Surgery
  - Type: _______________
- ☐ Hernia Repair
  - [ ] Hiatal
  - [ ] Inguinal
  - [ ] Ventral
  - [ ] Umbilical
- ☐ Hip Replacement
  - [ ] Left [ ] Right [ ] Both
- ☐ Joint Surgery
  - Type: _______________
- ☐ Kidney Removal
  - [ ] Left [ ] Right
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
  - [ ] Left [ ] Right
- ☐ Knee Replacement
  - [ ] Left [ ] Right [ ] Both
- ☐ Loop Recorder
- ☐ Neck Surgery
- ☐ Pacemaker
  - Brand: _______________
- ☐ Portacath
- ☐ Tendon Surgery
  - Type: _______________
- ☐ Tonsils Removed
- ☐ Thyroid Removal
- ☐ Spleen Removal

Female:

- ☐ C-Section
- ☐ Dilation and Curettage
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Tubal Ligation

Male:

- ☐ Prostatectomy

Other surgeries not mentioned above: ____

Allergies: *Please list your allergies with the type of reaction you experienced or select "None"* [ ] None

Allergy:	Severity:	Reaction:
____________________	____________	____________________
____________________	____________	____________________
____________________	____________	____________________

Medication List: *Please list your medications and supplements or provide us with a list. If you do not take any medication , please select "None"* [ ] None

☐ Patient provided current medication list

Name:	Dosage:	Frequency:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

Other Conditions: ____

____

____

Patient Signature: *X* ____ Date: _____/ _____/ __________

Official use only: MRN#: ____________________ Account #: ________________