**MEDICAL HISTORY QUESTIONNAIRE**

NAME:.................................................................................................................................

DATE OF BIRTH:..............................................

We would appreciate your completing this questionnaire to aid in our service to you. If you have problems answering any of the questions do not hesitate to ask our technicians for help.

Why are you having this test?………………………………………………….……………...

Do you take any medications?.......................................

If yes, what are they?....…………………………………………………………………………………………………………………………………….

 Do you have any past medical history of: (circle correct response)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Heart attack | Yes | No | Previous heart operation | Yes | No |
| Angina (chest pain) | Yes | No | Family history of heart attack or vascular disease | Yes | No |
| Rheumatic fever | Yes | No | High blood pressure | Yes | No |
| Valvular heart disease | Yes | No | High cholesterol | Yes | No |
| Murmurs | Yes | No | Diabetes | Yes | No |
| Liver problems | Yes | No | Asthma | Yes | No |
| Kidney problems | Yes | No | Lung problems | Yes | No |

Do you smoke? …………….. If ex-smoker, number of years since stopped……….

**Do you experience any of the following symptoms? If so, could you briefly explain the nature of them**.

Chest pain …………………………………………………………………………………………………………………

Shortness of breath ………………………………………………………………………………………………………

Palpitations ………………………………………………………………………………………………………………..

Blackouts / dizziness ……………………………………………………………………………………………………..

Ankle swelling ………………………………………………………………………………………………………………

Have you had any previous cardiac investigations? Yes / No