Cardio Vascular Surgeons of North Texas

NAME_____D.O.B_____DATE:_____

PATIENT QUESTIONAIRE: Welcome to our office, please answer the following questions to the best of your ability, so that we will be able to provide you with better medical care.
Thank you.

Names of your doctors: _____
And their specialty

_____

_____

_____

PREVIOUS / CURRENT MEDICAL ILLNESS:

	YES	NO		YES	NO
ABDOMINAL PAIN	_____	____	KIDNEY DISEASE	_____	_____
CANCER	_____	____	LIVER DISEASE	_____	_____
CHEST PAINS	_____	____	PALPITATIONS	_____	_____
EASY BLEEDING	_____	____	PNEUMONIA	_____	_____
EDEMA	_____	____	SEIZURES	_____	_____
FAINTING/PASSING OUT	_____	____	SHORTNESS OF BREATH	_____	_____
HEART ATTACK	_____	____	SNORING	_____	_____
HEARTBURN/INDIGESTION	_____	____	TUBERCULOSIS	_____	_____
HIGH BLOOD PRESSURE	_____	____			

ARE YOU CURRENTLY TAKING:

ASPRIN	_____	____
COUMADIN	_____	____
PLAVIX	_____	____

PREVIOUS SURGERY / HOSPITALIZATIONS (non surgery related)

Type of Surgery Mo/Year

_____

_____

_____

_____

_____

_____

_____