

**LEONARD J. SCUDERI, M.D., F.A.C.C.**

Diplomate, American Boards of Internal Medicine & Cardiovascular Diseases

**CardioFit Medical Group, Inc.**

**PREVENTIVE AND INTERVENTIONAL CARDIOLOGY**

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**CARDIOVASCULAR HEALTH QUESTIONNAIRE**

Last name      First name      M.I.

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Age \_\_\_\_ years, Today's  
date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Welcome to the cardiology practice of Dr. Leonard J. Scuderi, CardioFit Medical Group, Inc. We look forward to providing you with the finest cardiovascular care available. The following questionnaire will assist us in collecting all relevant medical information in anticipation of your upcoming cardiology consultation with Dr. Scuderi. It will make it possible for Dr. Scuderi to thoroughly evaluate your cardiovascular status, and provide you with a comprehensive, up-to-date, easily explained summary of your cardiac status.

**Please read the following two bulleted items carefully:**

- ***This CARDIOVASCULAR HEALTH QUESTIONNAIRE, as well as, accompanying PATIENT DEMOGRAPHIC FORM, PATIENT INSURANCE FORM, AND OFFICE POLICY NOTICE must be completed in their entirety and received by our office at least 24 hours PRIOR TO YOUR APPOINTMENT WITH THE CLINICAL SPECIALIST (the first of your two visits).***
- ***Please note that a self-addressed envelope is enclosed for your convenience in order for you to meet this deadline. Thank you for your cooperation as we assist you in attaining optimal cardiovascular health.***

Most of the questions are self-explanatory and merely require a checkmark, "yes" or "no" answer, or several-word response. If you have any difficulty completing this form, then please call our office well in advance of your appointment with the Clinical Specialist so that you may obtain clarification of any portion of the questionnaire that you are unable to complete. Note that your appointment with the Clinical Specialist precedes your appointment with the doctor. Thank you in advance for your participation in providing us with this vital information; your time and effort are truly appreciated.

- Who referred you to Dr. Scuderi (physician, family member, friend)?
  
- Please list all physicians with whom you follow-up and to whom you wish to receive a copy of your upcoming cardiology consultation:

Specialty	Dr.'s First name	Last name	City
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- What is the primary problem for which you have been referred?

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- What questions would you like addressed in order of importance?

1.

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2.

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3.

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4.

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### Current Cardiovascular History

• Please carefully read the symptom descriptions below.  
Use a red pen to place a checkmark “√” within the brackets below  
corresponding to any symptoms that you have experienced within the last  
three months.

1.  **Discomfort/ache** involving your chest, neck, jaw, left shoulder, left arm, or back but never occurs during physical activity (leisure walking, brisk walking, walking up stairs, or jogging)?
2.  **Discomfort/ache** involving your chest, neck, jaw, left shoulder, left arm, or back consistently precipitated by physical activity (leisure walking, brisk walking, walking up stairs, or jogging) and is relieved by rest?
3.  Difficulty breathing during physical activity and is relieved by rest?
4.  Difficulty breathing while lying down, but does not occur when propping oneself up with more pillows?
5.  Awakening in the middle of the night, gasping for air, but not for just a few seconds and not related to nightmares?
6.  Ankle swelling?
7.  Muscle soreness specifically meeting all of the following?  
lasting hours on a daily basis, and  
involving both sides of your body, and  
lasting at least one week, and  
not related to trauma, and  
not simply muscle cramps lasting seconds to minutes

8.  Persistent calf pain not episodic muscle cramps?
9.  Fatigue or discomfort involving one or both of your legs upon walking a predictable distance and resolves within a few minutes of stopping?
10.  Palpitations, irregular heart beat, or thumping sensation within your chest?
11.  Lightheadedness? Not vertigo or a spinning sensation.
12.  Severe lightheadedness to the point where you need to hold onto something for fear that if it were to worsen, you might lose consciousness and fall? Not vertigo or a spinning sensation that would cause you to simply stumble and fall while being alert.
13.  Passing out, losing consciousness, or fainting?
14.  Persistent fatigue, tiredness, or lack of energy?
15.  Weakness isolated to one side of your body involving an arm and/or leg?
16.  Inability to move one side of your body involving an arm and/or leg?
17.  Transient loss of vision involving a particular area of your visual field or as though a black curtain were being pulled over your eyes?
18.  Severe headaches of the magnitude that you would consider to be the worst you have ever experienced in your life?
19.  Persistent fevers recorded by a thermometer lasting more than one week?

20.  Profuse perspiration occurring at rest?
21.  Coughing with or without sputum or phlegm production (specify)?
22.  Coughing up blood?
23.  Persistently poor appetite?
24.  Persistent nausea?
25.  Discomfort located in the upper center of your abdomen?
26.  Bright red blood from the rectum or red stools, not related to constipation or hemorrhoids?
27.  Black, not dark brown, stools?
28.  Vomiting blood?
29.  Frequent or profuse nosebleeds?
30.  Significant, not merely mild, bruising?

### Past Cardiovascular History

- Please place a red checkmark “√” within the brackets below corresponding to any item that you have been made aware of regarding your past medical history. Do any of the following apply to you? If you are unsure, then place a “question mark within the brackets.
1.  Less than ideal blood lipid, cholesterol, or triglyceride profile? If so, since what year? . The “ideal” profile would depend upon the presence of coronary artery disease or risk factors for coronary artery disease. The purpose of this question is to determine whether any physician has expressed concern about your profile in the past. If so, then place a checkmark above and enter the year corresponding to when you were first told.
  2.  Diabetes (elevated blood sugar)? If so, since what year?
  3.  Family history of premature coronary artery disease? Specifically, relatives known to have developed coronary artery disease, heart attack, undergone bypass surgery, or sudden cardiac death at the age of less than 55 years in male relatives or less than 65 years in female relatives?
  4.  Obesity? For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the “body mass index” (BMI). BMI is used because, for most people, it correlates with their amount of body fat. An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. Today, we will provide you with your BMI in order to identify obesity as a potential risk factor for coronary artery disease.  
If you are obese, then since what year?  
  
 Please check this item if you are committed to losing excess weight.

If you would like to know your BMI at any time while at home, you may use the CDC website to calculate the number within seconds.

<http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>

5.   Metabolic or insulin resistance syndrome? If so, since what year, have you had three or more of the following criteria that are required to diagnose this disorder?

Yes No ?

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased abdominal girth: men >40 in., women > 35 in.   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Increased triglycerides blood levels: > 150 mg/dL        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HDL cholest: < 40 mg/dL (men) < 50 mg/dL (women)         |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fasting blood sugar $\geq$ 110 mg/dL                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systolic blood pressure (top number) $\geq$ 130 mm Hg    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diastolic blood pressure (bottom number) $\geq$ 85 mm Hg |

6.  Elevated lipoprotein (a) blood level?
7.  Elevated homocysteine blood level?
8.  Elevated cardiac/high-sensitivity C. reactive protein (CRP) blood level?
9.  Coronary calcification by Electron Beam CT (EBCT) scanning?
10.  Carotid artery disease (arterial blockage involving the neck)? If so, since what year?
11.  Carotid endarterectomy (surgical removal of carotid artery plaque)? If so, what year?
12.  Peripheral artery disease (arterial blockages most commonly involving the legs)? If so, since what year?
13.  Peripheral bypass graft surgery (surgery providing alternative flow to the limbs)? If so, what year?

14.  Transient ischemic attack (TIA). This is characterized by temporary speech difficulty, loss of vision, or loss of function involving a hand or leg on one side of the body lasting less than 24 hours? If so, what year?

15.  Stroke (characterized by speech difficulty, loss of vision, or loss of function involving a hand or leg on one side of the body lasting more than 24 hours)? If so, what year?

16.  Congestive heart failure (shortness of breath caused by fluid in the lungs)? If so, due to either:

Yes No ?

Systolic heart failure (enlarged, weakened heart)?

Diastolic heart failure (thickened, stiff heart muscle that pumps strongly but does not relax appropriately)?

17. [ ] Coronary artery disease (arterial blockage involving the coronary arteries)?

If so, have you experienced or undergone any of the following:

Yes No ?

Heart attack?

Coronary angioplasty?

Coronary stenting?

Coronary artery bypass graft surgery?

If so, what year?



18.  Arrhythmia (heart rhythm disorder)? If so, since what year?  
Please check any of the following terms you may recognize as pertaining to your own past:
- Atrial premature complexes (APC's, PAC's)
  - Atrial fibrillation
  - Atrial flutter
  - Supraventricular tachycardia (SVT)
  - Ventricular premature complexes (VPC's, PVC's)
  - Ventricular tachycardia
  - Heart block
  - Bradycardia (slow heart rate)
19.  Pacemaker implantation? If so, refer to your pacemaker card to provide the following information:
- Year implanted?  
Brand? [Biotronik, Guidant, Medtronic, St. Jude]  
Month/year of last generator replacement [ \_\_/200\_\_ ]  
Month/year of last pacemaker interrogation [ \_\_/200\_\_ ]
20.  Sudden cardiac death? (sudden, unexpected death caused by loss of heart function. Most sudden cardiac deaths are caused by arrhythmias? If so, what year?
21.  Hypertension (elevated blood pressure on three or more occasions in the absence of pain)? If so, since what year?
- Yes No ?
- Systolic blood pressure (top number)  $\geq$  130 mm Hg
  - Diastolic blood pressure (bottom number)  $\geq$  85 mm Hg
22.  Hypertensive heart disease (thickened heart muscle most commonly due to elevated blood pressure)? If so, since what year?

23.  Hypertrophic cardiomyopathy (thickened, stiff heart muscle not due to an elevated blood pressure, pumps strongly, but does not relax appropriately)? If so, since what year?

24.  Heart murmur (heart sound documented by a physician after listening with a stethoscope)? If so, since what year?

25.  Mitral valve prolapse (longer than usual leaflet(s) length resulting in a bowing backward appearance of the mitral valve as seen during echocardiography (ultrasound of the heart). This may be associated with regurgitation (leakage), and may lead to symptoms of episodic palpitations, chest discomfort, and anxiety. If so, since what year?

26.  Valvular regurgitation or leakage? Which of the four heart valves are involved? If so, since what year?

aortic    mitral    tricuspid    pulmonic    uncertain

27.  Valvular stenosis or narrowing? Which of the four heart valves are involved? If so, since what year?

aortic    mitral    tricuspid    pulmonic    uncertain

28.  Heart valve surgery? If so, what year?

If so, which valve was surgically treated?

aortic    mitral    tricuspid    pulmonic    uncertain

If so, was it repaired, or if replaced, what type of prosthesis used? (check one of following choices)

- repaired
- replaced with mechanical (metal) valve
- replaced with natural (porcine or bovine) valve

29.  Congenital heart disease?  
If corrected surgically, what year?  
 Bicuspid aortic valve?  
 Atrial septal defect?  
 Ventricular septal defect?  
 Coarctation of aorta?
30.  Take antibiotic prior to dental cleaning?
31.  Pericarditis (inflammation of the lining surrounding the heart)?  
If so, what year?
32.  Endocarditis (heart valve infection)? If so, what year?
33.  Myocarditis (viral infection causing the heart muscle to become enlarged and weakened)? If so, what year?
34.  Aortic aneurysm? If so, what year?
35.  Aortic dissection? If so, what year?
36.  Aortic surgery for aneurysm? If so, [ ] chest or [ ] abdomen  
If so, what year?
37.  Pulmonary hypertension (increased pressure within right side of heart)? If so, what year?
38.  Pulmonary embolism (PE)? This is characterized by sudden difficulty breathing, chest discomfort, and lightheadedness due to blood clots traveling from the lower body to the lung circulation.
39.  Deep venous thrombosis (DVT)? This condition most commonly involves a blood clot located within the deep veins of the thigh or calf, and is associated with leg pain and edema.

40.  Asthma? This condition causes episodic coughing, wheezing, and/or difficulty breathing related to air-borne allergens, cold air, or emotional stress.
41.  Pneumonia (infection of the lungs requiring a chest radiograph or x-ray to diagnose)? If so, what year?
42.  Pleurisy (viral inflammation of the lining of the lungs resulting in sharp pains during deep breathing but resolves immediately during breath holding)? If so, what year?
43.  Pneumothorax (puncture of the lung requiring surgical insertion of a chest tube for at least one day in order to allow re-expansion to occur)? If so, what year?
44.  Peptic ulcer disease? If so, what year?
45.  Gastrointestinal bleeding? If so, what year?
46.  Gastroesophageal reflux disorder (GERD) This condition is characterized by chronic heartburn and is exacerbated by obesity, coffee, chocolate, and acidic foods. If so, what year?
47.  Hiatal hernia? If so, what year?
48.  Esophagitis (inflammation of the esophagus resulting in chest discomfort)? If so, what year?
49.  Esophageal spasm? If so, what year?
50.  Pancreatitis (inflammation of the pancreas resulting from gallstone, alcohol abuse, or severely elevated blood triglyceride level)? If so, what year?
51.  Cholecystitis (painful gallstones)? If so, what year?

If so, have you had your gallbladder removed?  Yes  No  
If so, what year?

52.  Costochondritis (inflammation of the rib joints)?
53.  Musculoskeletal strain (pulled muscle within the last three months)?
54.  Fibromyalgia (chronic rheumatologic condition caused by chronic sleep deprivation and is characterized by muscle aches involving multiple areas)? If so, since what year?
55.  Rib fracture within last six months?
56.  Rheumatoid arthritis (RA)?
57.  Systemic lupus erythematosus (SLE)?
58.  Injury to? Please also indicate what year it occurred.
- |                                |                                   |   |
|--------------------------------|-----------------------------------|---|
| <input type="checkbox"/> head  | <input type="checkbox"/> shoulder | <input type="checkbox"/> cervical spine |
| <input type="checkbox"/> neck  | <input type="checkbox"/> arms     | <input type="checkbox"/> thoracic spine |
| <input type="checkbox"/> chest | <input type="checkbox"/> abdomen  | <input type="checkbox"/> lumbar spine   |
| <input type="checkbox"/> back  | <input type="checkbox"/> legs     | <input type="checkbox"/> sacral spine   |
59.  Radiculopathy (pain, numbness, tingling, or weakness involving your arms or legs caused by a problem with your nerve roots (branches of spinal cord carrying signals to rest of body))?
60.  Herpes zoster (Shingles)?
61.  Anxiety?
62.  Panic attacks?

63.  Cancer? If so,

- Year diagnosed
- Location
- Treatment
- Currently in remission  Yes  No
- Currently with metastasis  Yes  No
- Oncology appt w/i last year  Yes  No

64.  Weight gain or weight loss within last year  Yes  No

If yes, please estimate how much:

Gained                    lbs. over the last                    months  
Lost                                    lbs. over the last                    months

If weight loss, has this been because of:

Dieting                                     Yes     No  
Exercising                                     Yes     No  
Lack of appetite                                     Yes     No

65.  Have you ever had a blood transfusion?  Yes  No

If so, what year were you transfused? .

**Allergy History**

1. If you are allergic to any medications, then please name them below and place an “X” in the box that describes the specific type of reaction that you experienced with each particular medication.

	Medication	Rash	Hives	Difficulty breathing	Passed out	Other
1						
2						
3						

2. If you are allergic to any of the allergens below, then please place an “X” in the box that describes the specific type of reaction that you experienced with that particular allergen.

	Allergen	Rash	Hives	Difficulty breathing	Passed out	Other
1	Iodine					
2	Lobster					
3	Shrimp					
4	Dye					
5	Tape					
6	Latex					
7						

### Medications

- It is **extremely important** that the information you provide is current and accurate since errors in medication dosing are among the leading causes of preventable morbidity and mortality in the medical field.
- If you are not absolutely certain of the information, then it is **your responsibility** to call your pharmacist and/or your primary physician to obtain the necessary information being requested below. **Guessing is not an option when it comes to your medications.**
- Please list all medications that you are currently taking.
- If you do not know the name of the medications but have all of the medication bottles available at home, then please bring all medications with you at your upcoming office visit.
- Please do not omit birth control, diet pills, cold remedies, allergy shots, laxatives, or any over-the-counter medications.

For each medication, please use the guidelines below along with the two “example medications” (Med1 and Med2) in the mini-table below to assist you in properly completing your own medication table on the next page:

1. Clearly write the name of the medication.
2. Enter the milligram (mg) dosage of each tablet or capsule.
3. Enter the number of tablets or capsules taken each time.
4. Checkmark whether it is a tablet or capsule.
5. Checkmark the frequency daily (once, twice, three, or four times daily).  
Note: If once daily, then is it taken in AM, PM, or at bedtime?

	1.	2.	3.	4.		5.				5.		
	Medication name	mg of tab or cap	# of tabs or caps <u>each</u> time	Tab (✓)	Cap (✓)	Once daily if so, then ✓ AM or PM	A M ✓	P M ✓	B e d	Two times daily (✓)	Three times daily (✓)	Four times daily (✓)
1	Example Med1	10	1	✓		✓		✓				
2	Example Med2	325	2		✓						✓	



**Medication Table**

	1.	2.	3.	4.		5.			5.			
	Medication name	mg of tab or cap	# of tabs or caps <u>each</u> time	T a b √	C a p √	Onc e dail y if so, the n √ AM , PM or Bed	A M √	P M √	B e d √	Two times daily (√)	Three times daily (√)	Four times daily (√)
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Hospitalization History**

If you have been hospitalized for any reason, other than childbirth, please complete the following to the best of your abilities:

Year	Hospital	Reason

**Social History**

Birthplace:                      City                                      State

Occupation:  
(please √ if yes)       Retired

Exposure to:  
(please √ if yes)       Toxic chemicals  
                                  Radioactive materials  
                                  Asbestos

Marital Status:  
(please √ if yes)       Single  
                                  Happily married  
                                  Overly stressful marriage  
                                  Divorced  
                                  Widow/er

**CV HEALTH QUESTIONNAIRE**

**LEONARD J. SCUDERI, M.D., F.A.C.C.**

Tobacco:  Never  
(please  $\checkmark$  if yes)  Past  
 Active

If past or active smoker, please quantify your exposure:

Average daily exposure: packs per day  
Total exposure: years  
Quit how long ago: years ago

Current/Past use of chewing tobacco

If active smoker, please check this item at the left if you are committed to quitting.

Alcohol:  Never  
(please  $\checkmark$  if yes)  Past  
 Active

If past or active, please characterize:

Type of ethanol drink:  wine  
(please  $\checkmark$  if yes)  beer  
 liquor

**Weekly amount:** glasses  
**(please insert number)** bottles/cans  
drinks

Total exposure: years  
Quit how long ago: years ago

If active heavy drinker, please check this item if you are committed to quitting.

Exercise:  Not currently  
 (please  $\checkmark$  if yes)  Active

If active, please characterize:

$\checkmark$	Type of exercise	Min/session	Sessions/wk
<input type="checkbox"/>	Jogging		
<input type="checkbox"/>	Brisk walking		
<input type="checkbox"/>	Tennis		
<input type="checkbox"/>	Walk golf course		
<input type="checkbox"/>	Treadmill		
<input type="checkbox"/>	Elliptical		
<input type="checkbox"/>	Stairmaster		
<input type="checkbox"/>	Weight training		
<input type="checkbox"/>	Swimming		

Diet: [please  $\checkmark$  yes or no]

Adherence to:	Yes	No	Relationship
Low-fat intake	<input type="checkbox"/>	<input type="checkbox"/>	
Low-sodium intake	<input type="checkbox"/>	<input type="checkbox"/>	
Low-carbohydrate or diabetic-type diet	<input type="checkbox"/>	<input type="checkbox"/>	
Prudent calorie intake	<input type="checkbox"/>	<input type="checkbox"/>	

If you are committed at this time to changing the items above marked "No", then please checkmark the box to the left.

Do you consume caffeinated products?  Yes  No

Please indicate the amount of each product you consume on a daily basis:

cup(s) of coffee.

cup(s) of tea (including green tea). Do not include non-caffeinated tea products, such as chamomile.

can(s) of caffeinated soda (Coke, Pepsi, Mountain Dew).

ounce(s) of chocolate.

over-the counter medications that contain caffeine (Anacin, Excedrine, Midol, NoDoz, Vivarin).

Power (energy) drinks (Red bull, Monster, ect.)

**Family History**

1. Have any family members had any of the diseases or illnesses listed below? You may add any other ones in the spaces provided within the table below.

<b>Disease/Disorder</b>	<b>Yes</b>	<b>No</b>	<b>Relationship</b>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Undesirable cholesterol profile	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden death	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
Early unexplained death	<input type="checkbox"/>	<input type="checkbox"/>	

2. Please complete the table below with respect to each family member.

<b>Relation</b>	<b>Age</b>	<b>Health Problems</b>	<b>Age of Death</b>	<b>Cause of Death</b>
Grandmother				
Grandfather				
Mother				
Father				
Sister(s)				
Brother(s)				
Daughter(s)				
Son(s)				

**CARDIOVASCULAR DIAGNOSTIC TESTING**

- While you are not expected to be knowledgeable of the tests listed below, any information with which you may provide us may prevent **unnecessary duplication** of diagnostic testing especially regarding blood tests that may have recently been performed at other offices. If you are uncertain, then simply place a question mark alongside the test.

Test performed	Misc.	Approx how long ago?	Where done?
Potassium	Blood		
Glucose	Blood		
Kidney function	Blood		
Liver function	Blood		
Lipid profile	Blood		
High-sensitivity CRP	Blood		
Homocysteine	Blood		
Thyroid function	Blood		
Anemia	Blood		
Protime	Blood		
Electrocardiogram	EKG		
Chest radiograph	X-Ray		
Echocardiogram	Ultrasound		
Stress echo	Ultrasound		
Exercise testing	Treadmill		
Carotid ultrasound	Ultrasound		
Abdominal ultrasound	Ultrasound		
Heart cath/angiogram	Cath lab		
Coronary angioplasty	Cath lab		
Coronary stenting	Cath lab		

**Congratulations. You have completed your cardiovascular health questionnaire. Your efforts are appreciated and will provide Dr. Scuderi with vital information regarding your current health.**

**I have completed the entire cardiovascular health questionnaire to the best of my knowledge.**

**Your printed name**

**Your signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ - \_\_\_\_\_