**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**
23456 Hawthorne Blvd, Skypark Bldg. 5, Suite 250 Torrance, CA 90505
**Phone (310) 791-5577** **Fax** (310) 791-5575

## CARDIOVASCULAR HEALTH QUESTIONNAIRE

Last name _____ First name _____ M.I.___

Date of birth ____/____/_____ Age _____ years Today's date____/____/_____

- 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 |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- What is the primary problem for which you have been referred? _____

  _____

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

1. _____

   _____

2. _____

   _____

## Current Cardiovascular History

- Please carefully read the symptom descriptions below. Use a 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 pain, chest tightness or chest pressure with or without physical activity? How many times a week? How long does the discomfort last?

2. [ ] Was your **chest discomfort** accompanied by neck, jaw, left shoulder, left arm, or back ?

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. [ ] Awaking 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. [ ] Are you having any muscle pain or cramps involving your arms or legs?

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. [ ] Passing out, losing consciousness, or fainting?

13. [ ] Persistent fatigue, tiredness, or lack of energy?

14. [ ] Weakness isolated to one side of your body involving an arm and/or leg?

15. [ ] Transient loss of vision involving a particular area of your visual field or as though a black curtain were being pulled over your eyes?

16. [ ] Severe headaches of the magnitude that you would consider to be the worst you have ever experienced in your life?

17. [ ] Persistent fevers recorded by a thermometer lasting more than one week?

18. [ ] Profuse perspiration occurring at rest?

19. [ ] Coughing with or without sputum or phlegm production (specify)?

20. [ ] Coughing up blood?

21. [ ] Persistently poor appetite?

22. [ ] Persistent nausea?

23. [ ] Discomfort located in the upper center of your abdomen?

24. [ ] Bright red blood from the rectum or red stools, not related to constipation or hemorrhoids?

25. [ ] Black, not dark brown, stools?

26. [ ] Vomiting blood?

27. [ ] Frequent or profuse nosebleeds?

28. [ ] Significant, not merely mild, bruising?

## Past Cardiovascular History

- Please place a 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? _____.

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

5. [ ] Coronary calcification by Electron Beam CT (EBCT) scanning?

6. [ ] Carotid artery disease (arterial blockage involving the neck)? If so, since what year? _____

7. [ ] Carotid endarterectomy (surgical removal of carotid artery plaque)? If so, what year? _____

8. [ ] Peripheral artery disease (arterial blockages most commonly involving the legs)? If so, since what year? _____

9. [ ] Peripheral bypass graft surgery (surgery providing alternative flow to the limbs)? If so, what year? _____

10. [ ] 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? ____

11. [ ] 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? _____

12. [ ] Congestive heart failure (shortness of breath caused by fluid in the lungs)?

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

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

| Yes | No | ? | | If so, what year? |
|---|---|---|---|---|
| [ ] | [ ] | [ ] | Heart attack? | _____ |
| [ ] | [ ] | [ ] | Coronary angioplasty? | _____ |
| [ ] | [ ] | [ ] | Coronary stenting? | _____ |
| [ ] | [ ] | [ ] | Coronary artery bypass graft surgery? | _____ |

14. [ ] 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)

15. [ ] 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_ ]

16. [ ] Sudden cardiac death? (sudden, unexpected death caused by loss of heart function. Most sudden cardiac deaths are caused by arrhythmias? If so, what year? _____

17. [ ] 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) ≥ 85 mm Hg

18. [ ] 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? _____

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

20. [ ] 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?

_____

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

[ ] aortic [ ] mitral [ ] tricuspid [ ] pulmonic [ ] uncertain

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

[ ] aortic [ ] mitral [ ] tricuspid [ ] pulmonic [ ] uncertain

23. [ ] 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

24. [ ] Congenital heart disease?

If corrected surgically, what year?

[ ] Bicuspid aortic valve? _____
[ ] Atrial septal defect? _____
[ ] Ventricular septal defect? _____
[ ] Coarctation of aorta? _____

25. [ ] Take antibiotic prior to dental cleaning?

26. [ ] Pericarditis (inflammation of the lining surrounding the heart)?
If so, what year? _____

27. [ ] Endocarditis (heart valve infection)? If so, what year? _____

28. [ ] Myocarditis (viral infection causing the heart muscle to become enlarged and weakened)? If so, what year? _____

29. [ ] Aortic aneurysm? If so, what year? _____

30. [ ] Aortic dissection? If so, what year? _____

31. [ ] Aortic surgery for aneurysm? If so, [ ] chest or [ ] abdomen
If so, what year? _____

32. [ ] 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.

33. [ ] 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.

34. [ ] Asthma? This condition causes episodic coughing, wheezing, and/or difficulty breathing related to air-borne allergens, cold air, or emotional stress.

35. [ ] Pneumonia (infection of the lungs requiring a chest radiograph or x-ray to diagnose)? If so, what year? _____

36. [ ] 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? _____

37. [ ] 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? _____

38. [ ] Peptic ulcer disease? If so, what year? _____

39. [ ] Gastrointestinal bleeding? If so, what year? _____

40. [ ] 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? _____

41. [ ] Hiatal hernia? If so, what year? _____

42. [ ] Esophagitis (inflammation of the esophagus resulting in chest discomfort)? If so, what year? _____

43. [ ] Esophageal spasm? If so, what year? _____

44. [ ] Pancreatitis (inflammation of the pancreas resulting from gallstone, alcohol abuse, or severely elevated blood triglyceride level)? If so, what year? _____

45. [ ] Cholecystitis (painful gallstones)? If so, what year? _____

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

46. [ ] Costochondritis (inflammation of the rib joints)?

47. [ ] Musculoskeletal strain (pulled muscle <u>within the last three months</u>)?

48. [ ] Fibromyalgia (chronic rheumatologic condition caused by chronic sleep deprivation and is characterized by muscle aches involving multiple areas)? If so, since what year? _____

49. [ ] Rib fracture within last six months?

50. [ ] Rheumatoid arthritis (RA)?

51. [ ] Systemic lupus erythematosis (SLE)?

52. [ ] Injury to? Please also indicate what year it occurred.

[ ] head ____ [ ] shoulder ____ [ ] cervical spine ____
[ ] neck ____ [ ] arms ____ [ ] thoracic spine ____
[ ] chest ____ [ ] abdomen ____ [ ] lumbar spine ____
[ ] back ____ [ ] legs ____ [ ] sacral spine ____

53. [ ] Herpes zoster (Shingles)?

54. [ ] Anxiety?

55. [ ] Panic attacks?

56. [ ] 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

57. [ ] 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 and/or food, then please indicate below and place an "X" in the box that describes the specific type of reaction that you experienced.

| | Medication | Rash | Hives | Difficulty breathing | Passed out | Other |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |

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

## Medications

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?

### Medication Table

| | Medication Name | #mg | Tablet or Capsule | Frequency of Dose/Time of day (a.m., p.m., bedtime, etc.) |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |

## 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

Tobacco:
(please **√** if yes**)**
[ ] Never
[ ] 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 **√** if yes**)** [ ] Past
[ ] Active
If past or active, please characterize:

Type of ethanol drink: [ ] wine
(please **√** 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 **√** if yes**)** [ ] Active

If active, please characterize:

| **√** | Type of exercise | Min/session | Sessions/wk |
|---|---|---|---|
| | Jogging | | |
| | Brisk walking | | |
| | Tennis | | |
| | Walk golf course | | |
| | Treadmill | | |
| | Elliptical | | |
| | Stairmaster | | |
| | Weight training | | |
| | Swimming | | |

Diet: [please **√** yes or no]

| **Adherence to:** | **Yes** | **No** | **Relationship** |
|---|---|---|---|
| Low-fat intake | | | |
| Low-sodium intake | | | |
| Low-carbohydrate or | | | |

| | | | |
|---|---|---|---|
| diabetic-type diet | | | |
| Prudent calorie intake | | | |

[ ] 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.)

What is your daily intake of fluids:
(water, juice, ect.) _____ounces/liters.

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

| Relation | Age | Health Problems | Age of Death | Cause of Death |
|---|---|---|---|---|
| Grandmother | | | | |
| Grandfather | | | | |
| Mother | | | | |
| Father | | | | |
| Sister(s) | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| | | | | |
| Brother(s) | | | | |
| | | | | |
| | | | | |
| Daughter(s) | | | | |
| | | | | |
| | | | | |
| Son(s) | | | | |
| | | | | |
| | | | | |