Delaware
Heart and Vascular Group

Newark office:
94A Omega Drive, Newark DE 19713

Middletown office:
222 Carter Dr, Middletown, DE 19709

Wilmington office:
2500 Grubb Rd Ste 123A, Wilmington, DE 19810

Phone: 302-550-DHVG (3484)

Fax: 302-556-DHVG (3484)

Email: general@delhvg.com

Website: www.delhvg.com

Cardiology History Questionnaire

Name _____ Date of Birth _____

Primary Care Doctor: _____ Pharmacy/Location: _____

Are you adopted, or do not know your parents' health history? (Y / N)

****Please only check conditions that apply****

Disease/Condition	*Self*	*Mother*	*Father*	*Brother*	Sister	*Grandparent (M/F)*
Abnormal EKG						
Atrial Fibrillation						
Irregular Heart Beat						
Arrhythmia						
Pacemaker						
Defibrillator						
Cardiomyopathy						
Enlarged Heart						
Congestive Heart Failure						
Sudden Cardiac Death (including age)						
Angina						
Coronary Artery Disease						
Cardiac Catheterization						
Coronary Bypass						
Stent Placement						
Heart attack (including age)						
Heart Murmur						
Heart Valve Disease						
Aneurysm (Aorta)						

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Disease/Condition	*Self*	*Mother*	*Father*	*Brother*	*Sister*	*Grandparent (M/F)*
High Blood Pressure						
High Cholesterol						
Sleep Apnea						
Stroke						
TIA						
Diabetes						
Kidney Disorder						
Liver Disorder						
Pulmonary Embolism						
Cancer						
Dementia						
COPD						
Emphysema						
Aneurysm (Brain)						

Any other diseases that run in your family not mentioned above? Yes [ ] No [ ]
If Yes, please explain:_____

Have you had any of these symptoms in the past 2 weeks:

[ ] Chest Pain [ ] Shortness of Breath [ ] Difficulty Breathing

[ ] Jaw Pain [ ] Swelling of Extremities [ ] Left Sided Pain

Allergies to Medications: _____

Please list your Current Medication Names, Milligrams and Dosage Instructions:

_____

_____

_____

_____

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Alcohol Usage: [ ] Current [ ] Past [ ] Never

How often? _____ Type Consumed?_____

Tobacco Usage: [ ] Current [ ] Past [ ] Never

Type used?_____ How much per day? _____ Years Used? _____

Electronic Vape Usage: [ ] Current [ ] Past [ ] Never

Substance Usage: [ ] Current [ ] Past [ ] Never

Types of Substances Used? _____ How long ago? _____

Employment: [ ] Employed [ ] Retired [ ] Unemployed

Type of work do you perform? _____

Marital Status [ ] Single [ ] Married [ ] Widowed

[ ] Divorced [ ] Life Partner [ ] Separated

Exercise/Activity [ ] Never [ ] Occasional [ ] Daily

Please Describe what Kind: _____

_____

Please Note anything you would like the physician to be aware of:

_____

_____

_____

_____

_____