Center for Advanced Cardiovascular Care™

The Heart Hospital Baylor Plano

Cardiovascular Genetics Clinic
Vascular Questionnaire

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Date of Birth: _____

Primary Care Physician: _____

Why have you been referred for a Cardiovascular Genetics Appointment? _____

Have you had a genetics evaluation? If so, explain: _____

Have you had any genetic testing? If so, what were the results? _____

Who is your referring physician? _____

What is your race or ethnic background? If you are multi-racial, check all that apply: ☐ White ☐ Black ☐ Hispanic

☐ Asian ☐ E. Indian ☐ French Canadian ☐ Mediterranean/Greek/Italian ☐ Native American Indian ☐ Multi-racial

☐ Other: _____

☐ Adopted

☐ Ashkenazi Jewish descent

What country is your mother's family from? _____

What country is your father's family from? _____

What is the highest level of education you completed? ☐ Elementary school ☐ Middle school ☐ High school ☐ Some college

☐ College degree ☐ Graduate/Professional degree

What is your occupation? _____

Your current height _____

Your current weight _____

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Surgical History

Type of Surgery	Date	Physician & Location

Imaging History

Type of Imaging (CT, MRI, Echocardiogram…)	Date	Physician & Location	Result of Study

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Medical History Questionnaire

Do you or your family members have a history of any of the following?

	Self	Family Member (who?)	Explain
High Blood Pressure			
High Cholesterol			
Diabetes			
Stroke			
Neuropathy			
Other neurologic problems (seizures, migraines)			
Cardiomyopathy			
Coronary artery disease or heart attack			
Pacemaker or ICD			
Vascular or blood vessel problems			
Bypass Surgery			
Heart Transplant			
Muscle Disease/Weakness			
Cancer (indicate type)			
Lung Problems (ex: collapsed lung, pneumothorax)			
Other major medical conditions			
Miscarriages or sudden infant death?			
Do you smoke? Have you ever smoked?			
Do you use drugs?			
Do you drink alcohol?			

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Characteristics

Do you or any of your family members have any of the following characteristics?

	Self	Family Member (who?)	Explain
Eye problems			
Cleft lip and/or cleft palate			
Pectus excavatum or pectus carinatum (chest caves in or out)			
Scoliosis (curvature of the spine)			
Long fingers			
Long arm span			
Flat feet			
Joint flexibility			
Hernia			
Bruise easily			
Wound healing problems			
Skin abnormality			
Poorly healed scars			

Your Family Tree

Mother's Age: (now or age deceased)			Father's Age: (now or age deceased)		
	Total *Indicate half siblings*	Ages		Total *Indicate half siblings*	Ages
How many sisters do you have?			How many brothers do you have?		
How many daughters do you have?			How many sons do you have?		
How many maternal aunts do you have?			How many maternal uncles do you have?		
How many paternal aunts do you have?			How many paternal uncles do you have?		

Has anyone in your family had genetic testing? ☐ Yes ☐ No

If yes, what were the results? _____

(If yes, please bring a copy of your family member's test result to your appointment.)

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Review of Systems

Are you experiencing or have you ever experienced any of the below?
Please check the appropriate box(es).

General:	☐ Fatigue ☐ Fever ☐ Chills ☐ Recent weight change
Eyes:	☐ Blindness ☐ Glasses ☐ Vision problems ☐ Eye Surgery
Ears:	☐ Hearing impaired/Deaf ☐ Frequent ear infections ☐ Tinnitus (ringing) ☐ Vertigo (dizziness/feeling of motion)
Nose/Mouth/Throat:	☐ Anosmia ☐ Dental problems ☐ Difficulty swallowing ☐ Epistaxis (nose bleeds)
Respiratory:	☐ Asthma ☐ Cough ☐ Frequent pneumonias ☐ Dyspnea (shortness of breath)
Cardiovascular:	☐ Murmur ☐ Syncope (fainting) ☐ Cyanosis (blue) ☐ Edema (swelling)
Hematology/ Lymphatic:	☐ Easy bleeding ☐ Transfusions ☐ Anemia
Gastrointestinal:	☐ Nausea or Vomiting ☐ Bloody stools ☐ Jaundice ☐ Heartburn or Indigestion
Musculoskeletal:	☐ Joint laxity ☐ Joint pain or stiffness ☐ Fractures ☐ Limb abnormalities
Renal/Urinary:	☐ Dysuria (painful urination) ☐ Incontinence ☐ Frequent UTIs ☐ Hematuria (blood in urine) ☐ Kidney stones
Neurological:	☐ Seizures ☐ Headache ☐ Gait abnormalities ☐ Numbness or Tingling ☐ Memory loss
Psychological:	☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ ADHD ☐ Schizophrenia
Endocrine:	☐ Thyroid problems ☐ Polydipsia (thirst) ☐ Polyphagia (hunger) ☐ Heat or cold intolerance ☐ Hirsutism (excess hair)
Integument:	☐ Birthmarks ☐ Rashes ☐ Hypo- or Hyperpigmented macules ☐ Keloids
Allergy/ Immunology:	☐ Drug allergies ☐ Allergies to other substances ☐ Seasonal allergies ☐ Immune problems