



Cardiovascular Genetics Clinic Cardiomyopathy 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 _____



Surgical History

Type of Surgery	Date	Physician & Location

Imaging History

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



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?			



Your Family Tree

Mother's Age: (now or age deceased)	Father's Age: (now or age deceased)
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	Total <i>Indicate half siblings</i>	Ages		Total <i>Indicate half siblings</i>	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.)



Review of Systems

Are you experiencing or have you ever experienced any of the below?

Please check the appropriate box(es).

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