 **Carolina Cardiology, Sleep & Obesity Center, PC**

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**New Patient Questionnaire**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you ever seen Dr Mitra before? [ ] YES OR [ ] NO
* Ever been seen by any other cardiologist? [ ] YES OR [ ] NO
* IF YES: WHEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, WHO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY: Have you ever had any of the following problems?**

( ) HEART ATTACK ( ) OBESITY

( ) CONGESTIVE HEART FAILURE ( ) ANEMIA

( ) ENLARGED HEART ( ) CORONARY ARTERY DISEASE

( ) HEART MURMUR ( ) AICD OR PACEMAKER DATE OF IMPLANT: \_\_\_\_\_\_\_\_

( ) RHEUMATIC FEVER ( ) DIABETES

( ) HIGH BLOOD PRESSURE ( ) FIBROMYALGIA

( ) HEART VALVE DISORDER ( ) CANCER TYPE: \_\_\_\_\_\_\_\_

( ) PULMONARY EMBOLISM ( ) DIALYSIS

( ) HERNIA ( ) HIGH CHOLESTEROL

( ) SYNCOPE ( ) PERIPHERAL ARTERY DISEASE

( ) SEIZURES ( ) STROKE

( ) ANXIETY ( ) CHRONIC OBSTRUCTIVE PULMONARY DISEASE

( ) DEPRESSION ( ) ATRIAL FIBRILLATION

( ) GLAUCOMA ( ) GASTROESOPHAGEAL REFLUX DISEASE

( ) CATARACTS ( ) IRRITABLE BOWEL SYNDROME

( ) DEAFNESS ( ) RESTLESS LEG SYNDROME

( ) THYROID DISORDER ( ) DEGENERATIVE DISK DISEASE

( ) RENAL FAILURE ( ) CORRECTIVE LENSES

( ) POST TRUAMTIC STRESS DISORDER ( ) TINNITUS (RINGING IN EARS)

( ) WEIGHT LOSS SURGERY -TYPE/WHEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER PROBLEMS NOT LISTED ABOVE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*OPERATIONS/PREVIOUS SURGERIES\*\*\*\*\***

( ) CATHERIZATION ( ) HEART BYPASS ( ) HEART STENT ( ) ABLATION ( ) CARDIOVERSION

( ) ENDARTECTOMY ( ) PACEMAKER/DEFRILLATOR PLACEMENT ( ) PERIPHERAL VASCULAR STENTS

( ) ADENOIDECTOMY ( ) TONSILLECTOMY ( ) PERIPHERAL VASCULAR SURGERY

OTHER HEART/ SLEEP RELATED SURGERIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: Please include over the counter and vitamins and please include strength and dosing instructions**

\*\*\*\*\*MEDICATIONS\*\*\*\*\* ( NOT REQUIRED TO BE COMPLETED IF MEDICATION BOTTLES BROUGHT)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ALLERGIES: PLEASE LIST ANY DRUG ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL HISTORY:**

**TOBACCO HISTORY:**

( ) CURRENT SMOKER ( ) FORMER SMOKER ( ) NEVER A SMOKER

\_\_\_\_\_ PACKS PER DAY QUIT HOW LONG AGO? \_\_\_\_\_\_

**ALCOHOL HISTORY:**

( )ALOCHOLIC ( ) OCCASIONAL DRINKER ( ) SOCIAL DRINKER ( ) NEVER DRINK

**ILLICIT DRUG USE:**

( ) YES IF YES, WHAT TYPE/ HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) NO

**EXERCISE:** HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHAT TYPE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*FAMILY HISTORY\*\*\*\*\***

( ) HIGH BLOOD PRESSURE ( ) DIABETES ( ) HEART DISEASE ( ) HEART FAILURE

( ) ANGINA ( ) HEART ATTACK ( ) HIGH CHOLESTEROL ( ) CARDIOMYOPATHY

( ) STROKE ( ) ATRIAL FIBRILLATION

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Patient Signature Date

**\*IF YOU GO TO ONSLOW HOSPITAL, REQUEST DR. MITRA\***