Providence HEALTH CARE

# SPH CHEST PAIN CLINIC QUESTIONNAIRE

* 1 0 3 1 9 *

Medical Questionnaire

**St. Paul's Hospital Chest Pain Clinic**
200 - 1033 Davie Street, Vancouver, BC, V5E 1M7
**Phone: 604-296-0655 FAX: 604-689-4219**
Email: ChestPainClinic@providencehealth.bc.ca

Please complete this questionnaire as best as you can before your visit. Your answers will help us better treat you.

Date: _____

Full Name: _____ Age: _____ Date of birth: _____

Referring Dr. _____ Family Dr. _____

Height: _____ Weight: _____ Email: _____

## MEDICAL HISTORY

Please tell us about any previous **heart problems or procedures**, including heart attacks, hospital stays for heart issues, heart surgery, or angioplasty (stents). Include the date and the name of specialists:

| Year | Heart Problem or Procedure | Doctor (Specialist) |
|---|---|---|
| | | |
| | | |
| | | |

Please tell us about any **heart tests** you have had in the past, including exercise (treadmill) stress tests, nuclear tests (MIBI), echocardiogram (ultrasound), heart CT (CAT scan) or catheterization (coronary angiogram):

| Year | Heart Test | Doctor (Specialist) |
|---|---|---|
| | | |
| | | |
| | | |

Do you have any history of asthma (or ever needed to use an inhaler)? ☐ NO ☐ YES

Do you have any history of kidney problems? ☐ NO ☐ YES

Do you have any history of bleeding or stomach ulcers? ☐ NO ☐ YES

Do you have any **other medical conditions** or have you had any **other procedures** that are not mentioned above, including hospitalizations, complications of pregnancy, or surgeries? Include the year and name of specialist(s):

| Year | Diagnosis | Doctor (Specialist) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**MEDICATIONS:**

Please list all medications you are currently taking or attach a list. Include over the counter medications (e.g. ASPIRIN, TYLENOL), vitamins, and herbal remedies. Include the dose and how often you take it.
*Please use the last page if you need more space.*

| | |
|---|---|
| | |
| | |
| | |

**ALLERGIES:**

Are you allergic to any medications? ☐ NO ☐ YES - please list the medication(s) and your reaction below.

| | |
|---|---|
| | |

**RISK FACTORS FOR HEART DISEASE:**

Have you ever smoked regularly? ☐ NO ☐ YES - If yes, do you currently smoke? ☐ NO ☐ YES

What was the most number of cigarettes you smoked per day? _____

When did you quit? (date) _____

Do you drink alcohol? ☐ NO ☐ YES

If yes, how many drinks on average **per day**? _____ OR **per week**? _____

Have you ever been a heavy drinker? ☐ NO ☐ YES - If yes, what was the most per week? _____

Do you use recreational drugs? ☐ NO ☐ YES

If yes, please list what you currently use / have used: _____

When was your last use? (date) _____

How many caffeinated drinks (coffee, tea, cola) do you drink **per day**? _____ OR **per week**? _____

Have you ever been diagnosed with diabetes? ☐ NO ☐ YES - What year? _____

Do you have any complications from diabetes? ☐ NO ☐ YES

If yes, are the complications with: ☐ Kidneys ☐ Eyes ☐ Numbness of hands / feet

☐ Other: _____

Have you ever been diagnosed with high blood pressure? ☐ NO ☐ YES - What year? _____

What has your BP averaged lately? _____

Have you ever been diagnosed with high cholesterol? ☐ NO ☐ YES - What year? _____

Do you exercise regularly for a minimum of 20 minutes 3 times a week? ☐ NO ☐ YES

How would you describe your level of stress? ☐ Low stress ☐ Medium stress ☐ High stress

Do you follow a particular diet? ☐ NO ☐ YES - Please describe: _____

Have any immediate family members had heart issues before age 60? (hardened arteries, rhythm issues, unexpected death) ☐ NO ☐ YES – Provide diagnosis, age of onset, age at death (if relevant)

| | | |
|---|---|---|
| Father: | Brother(s): | Son(s): |
| Mother: | Sister(s): | Daughter(s): |

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Medical Questionnaire

**WHAT IS THE MAIN REASON THAT YOU HAVE BEEN REFERRED TO THE CHEST PAIN CLINIC?**

**CURRENT SYMPTOMS:**

***Chest pain***

Do you have chest pain? ☐ NO ☐ YES - Since when? _____

Describe the chest pain: ☐ Sharp ☐ Heavy ☐ Pressure ☐ Burning ☐ Dull ache ☐ Tight ☐ Other: (describe) _____

Where is the pain? ☐ Left chest ☐ Right chest ☐ Middle of chest ☐ Back

Does it travel to other areas? ☐ NO ☐ YES ☐ To jaw / neck ☐ Down arm (L or R) ☐ To back ☐ Other (describe): _____

What brings on the pain? (e.g. exercise, stress) _____

How long does the pain last each time? _____ **minutes** OR _____ **hours**

What relieves the pain? (e.g. rest, nitroglycerin) _____

How often does the pain occur? _____ x **per day** OR _____ x **per week** OR _____ x **per month**

***Shortness of breath***

How long can you walk on a flat surface or flight of stairs without stopping?

_____ **blocks** OR _____ **minutes** OR _____ **flights of stairs**

What makes you stop? ☐ Fatigue ☐ Shortness of breath ☐ Chest pain ☐ Leg/back pain ☐ Other (describe): _____

Do you have shortness of breath? ☐ NO ☐ YES

When is it present? ☐ Most of the time ☐ Just with exertion ☐ When I lie down

How many pillows do you sleep with under your head? ☐ 0-1 ☐ 2-3 ☐ 4 or more

Do you wake up at night short of breath? ☐ NO ☐ YES- How many times a week on average? _____

Do you have swelling of the ankles? ☐ NO ☐ YES - Since when? _____

***Claudication*** *(leg pain)*

Do you have pain / aching in your leg muscles when you walk? ☐ NO ☐ YES – Since when? _____

If yes, where do you feel it? ☐ Left leg ☐ Right leg ☐ Calf ☐ Thigh ☐ Buttock

Does it go away when you rest? ☐ NO ☐ YES

***Palpitations*** *(noticeable rapid, strong or irregular heartbeat)*

Do you ever feel palpitations? ☐ NO ☐ YES - please describe: _____

_____

(e.g. how long they last, fast or slow, regular or irregular)

***Other***

Do you ever pass out? ☐ NO ☐ YES - When was the last time? _____

Do you ever feel lightheaded? ☐ NO ☐ YES - describe _____

(e.g. spinning, feeling faint, imbalance, on standing, after moving head fast)

Do you have any other current symptoms you have not yet described: _____

**SOCIAL HISTORY:**

This information helps us understand your home and personal background, and any possible effect on your health or medical conditions.

Where were you born? _____

If other than BC, when did you move to BC? (date) _____

Current marital status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Separated ☐ Widowed ☐ Other: _____

Sexual Orientation: ☐ Heterosexual ☐ Same-sex ☐ Bisexual ☐ Other: _____ ☐ Prefer not to answer

How many biological children do you have? _____

Employment status: ☐ Currently employed ☐ Retired ☐ Semi-retired ☐ Looking for work ☐ On disability since: _____

Current or previous occupation: _____

**Do you have any questions you would like to ask us?**

Thank you for taking the time to complete this questionnaire. It provides us with helpful information and allows us to spend more time discussing relevant matters with you.

**ADDITIONAL NOTES**