Cardiac & Vascular INTERVENTIONAL GROUP
The CVI Group

Patient Questionnaire

Please complete the following **section(s)** that are pertinent to your visit **today**:

CHEST PAIN

1. Have you had any recent chest pain? ☐ yes ☐ no *IF yes, complete questions below*

   Location on chest (check all that apply): ☐ right side ☐ middle ☐ left side

   Is your chest pain associated with ☐ activity, ☐ rest, or ☐ both?

   If activity, what kind of activity? ☐ walking ☐ running ☐ climbing stairs ☐ all activities listed

   Duration of pain (check one): ☐ seconds ☐ minutes ☐ continuously

   Pain intensity (circle) None 0 1 2 3 4 5 6 7 8 9 10 worst pain ever

   Symptoms associated (check all that apply): ☐ nausea ☐ shortness of breath ☐ vomiting ☐ sweating

   List medication(s) or actions used for relief: _____

   _____

   _____

SHORTNESS OF BREATH

2. Have you had any recent shortness of breath? ☐ yes ☐ no *IF yes, complete questions below*

   Is your shortness of breath associated with ☐ activity, ☐ rest, or ☐ both?

   If activity, what kind of activity? ☐ walking ☐ running ☐ climbing stairs ☐ all activities listed

   Do you experience shortness of breath when lying flat? ☐ yes ☐ no *IF yes, complete question below*

   Do you need pillows for support? ☐ yes ☐ no If yes, how many pillows (circle)? 1 2 3 4 5

   Do you wake up suddenly from sleep unable to breathe? ☐ yes ☐ no IF yes, how often? _____

IRREGULAR HEART BEATS

3. Have you had any recent irregular heart beats? ☐ yes ☐ no *IF yes, complete questions below*

   Duration (check one) ☐ seconds ☐ minutes ☐ continuously

   Symptoms associated (check all that apply): ☐ nausea ☐ light headedness ☐ dizziness ☐ fainting

SWELLING

4. Have you noticed any swelling? ☐ yes ☐ no *IF yes, where?* _____

   Has the swelling been associated with shortness of breath? ☐ yes ☐ no

   Have you had rapid fluid weight gain in the last week or two? ☐ yes ☐ no *IF yes, how much* _____*lbs.*

Any recent ER visit? ☐ yes ☐ no *IF yes, provide hospital and date of discharge*

Hospital visited: _____

Date of discharge: _____

Do you need any of your cardiac medication renewed? ☐ yes ☐ no

Refills remaining can be picked up at your local pharmacy of choice

Is this visit related to a surgical clearance? ☐ yes ☐ no *IF yes, provide type of surgery and surgeon's name*

Type of surgery needed: _____

Name of Surgeon: _____

Date of surgery: _____