



# Cardiovascular Genetics Clinic Arrhythmia 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			
Learning Problems			
Other neurologic problems (seizures, migraines)			
Hearing Loss			
Cardiac Arrest			
Coronary artery disease or heart attack			
Pacemaker or ICD			
Vascular or blood vessel problems			
Arrhythmia disorder? (Long QT, SQT, CPVT, Brugada, ARVD)			
Fainting or passing out?			
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)

	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).*

<b>General:</b>	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Recent weight change
<b>Eyes:</b>	<input type="checkbox"/> Blindness <input type="checkbox"/> Glasses <input type="checkbox"/> Vision problems <input type="checkbox"/> Eye Surgery
<b>Ears:</b>	<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)
<b>Nose/Mouth/Throat:</b>	<input type="checkbox"/> Anosmia <input type="checkbox"/> Dental problems <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Epistaxis (nose bleeds)
<b>Respiratory:</b>	<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Frequent pneumonias <input type="checkbox"/> Dyspnea (shortness of breath)
<b>Cardiovascular:</b>	<input type="checkbox"/> Murmur <input type="checkbox"/> Syncope (fainting) <input type="checkbox"/> Cyanosis (blue) <input type="checkbox"/> Edema (swelling)
<b>Hematology/ Lymphatic:</b>	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Transfusions <input type="checkbox"/> Anemia
<b>Gastrointestinal:</b>	<input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Bloody stools <input type="checkbox"/> Jaundice <input type="checkbox"/> Heartburn or Indigestion
<b>Musculoskeletal:</b>	<input type="checkbox"/> Joint laxity <input type="checkbox"/> Joint pain or stiffness <input type="checkbox"/> Fractures <input type="checkbox"/> Limb abnormalities
<b>Renal/Urinary:</b>	<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
<b>Neurological:</b>	<input type="checkbox"/> Seizures <input type="checkbox"/> Headache <input type="checkbox"/> Gait abnormalities <input type="checkbox"/> Numbness or Tingling <input type="checkbox"/> Memory loss
<b>Psychological:</b>	<input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Schizophrenia
<b>Endocrine:</b>	<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)
<b>Integument:</b>	<input type="checkbox"/> Birthmarks <input type="checkbox"/> Rashes <input type="checkbox"/> Hypo- or Hyperpigmented macules <input type="checkbox"/> Keloids
<b>Allergy/ Immunology:</b>	<input type="checkbox"/> Drug allergies <input type="checkbox"/> Allergies to other substances <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Immune problems