Patient Name:

DOB:

MR #:

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Date: _____

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

CARDIOVASCULAR MEDICINE CLINIC RETURN QUESTIONNAIRE

Clinic Visit Date: _____ Time: _____ Last Visit Date: _____

Referring or Primary Care Physician: _____

Reasons for Today's Visit: _____

_____

Since Last Visit: Check any new diagnoses, symptoms, procedures you have had.	
DIAGNOSES	**PROCEDURES**
☐ Chest Pain	☐ Stress Test
☐ Breathing Problems	☐ Echocardiogram (Heart Ultrasound)
☐ Heart Attack	☐ Heart Catheterization
☐ Congestive Heart Failure	☐ Angioplasty (Balloon or Stent)
☐ Stroke	☐ Bypass Surgery ("CABG")
☐ High Blood Pressure	☐ Pacemaker
☐ Diabetes	
☐ Cholesterol	
☐ Palpitations	
☐ Lightheadedness / Dizziness	
☐ Leg or Buttock Pain with Walking	

List any surgeries, major illness and hospitalizations since last visit: _____

_____

_____

_____

_____

_____

List any changes to medications or doses since last visit: _____

_____

_____

_____

_____

_____

List any major changes to your work or family situation since last visit: _____

_____

_____

_____

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CARDIOVASCULAR MEDICINE CLINIC RETURN QUESTIONNAIRE

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Cardiovascular	**Gastrointestinal**	**Hematologic / Lymphatic**
☐ Pain or Discomfort in Chest	☐ Nausea or Vomiting	☐ Excessive Bleeding
☐ Shortness of Breath with Activity	☐ Heartburn or Indigestion	☐ Excessive Bruising
☐ Shortness of Breath Lying Flat	☐ Jaundice (yellow skin or eyes)	☐ Blood Clots
☐ Dizziness or Fainting	☐ Stomach or Abdominal Pain	**Endocrine**
☐ Palpitations or "Racing Heartbeat"	☐ Bloody or Black/Tarry Stools	☐ Excessive Urination
☐ Leg Swelling	☐ Change in Stool Pattern or Shape	☐ Excessive Thirst
☐ Awake at Night to Urinate	☐ Diarrhea	☐ Intolerance to Cold
☐ Leg or Buttock Pain with Walking	**Genitourinary**	☐ Intolerance to Heat
General	☐ Blood in Urine	**Neurologic**
☐ Recent Weight Changes	☐ Urinary Incontinence	☐ Memory Problems
☐ Severe Fatigue	☐ Erectile Dysfunction (Men)	☐ Weakness
☐ Loss of Appetite	**Women Only**	☐ Loss of Sensation
☐ Sleep Problems	☐ Completed Menopause	**Psychiatric**
☐ Fever or Chills	☐ Estrogen Use	☐ General Loss of Interest
☐ Excessive Sweating	☐ Breast Lump	☐ Depression
☐ Skin Rashes	☐ Vaginal Bleeding	☐ Anxiety
Head and Neck	**Musculoskeletal**	☐ Panic Attacks
☐ Headache	☐ Painful Muscles	☐ High Emotional Stress
☐ Vision Problems	☐ Painful Joints	
☐ Decreased Hearing	☐ Leg Cramps	
☐ Nasal Stuffiness	**Respiratory**	
☐ Difficulty Swallowing	☐ Cough	
☐ Painful Teeth or Gums	☐ Cough or Spit Up Sputum	
	☐ Cough or Spit Up Blood	
	☐ Shortness of Breath	
	☐ Wheezing	

List additional symptoms here: _____

_____

Signature of Patient/Representative: _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: □ Minor □ Incompetent/Incapacitated
Legal Authority: □ Legal Guardian □ Parent of Minor
□ Health Care Agent □ Other _____

Reviewed by: _____ Date: _____ Time: _____