Patients Visiting the Cardiology/Cardiovascular Surgery Department

Name:	Age:	Patient ID Number:
Phone (A number the hospital can contact when necessary)		Tel :

■ Please list the people you live with.

_____

■ What are the reasons/symptoms you are visiting for, and when did they start?

Ex) I was pointed out with abnormal electrocardiogram at my health screening／My chest sometimes feels tight from 1 year ago／I feel out of breath when I walk from 2~3 days ago, etc.

_____

_____

_____

■ Have you been pointed out with any illnesses before? Have you been hospitalized or undergone surgery before?

Allergies（ NONE ・ YES →

What are you allergic to? (Ex；Medicine, contrast, pollen, food, etc.)： ）

Asthma （ NO ・ YES→ When was your last attack? ： ）

Diabetes （ NO ・ YES from age_____）

High Blood Pressure （ NO ・ YES from age _____）

Other illnesses

（Diagnosis:_____ at age_____), Surgery （NO・YES_____）

（Diagnosis:_____ at age_____), Surgery （NO・YES_____）

（Diagnosis:_____ at age_____), Surgery （NO・YES_____）

■ For women: Is there a possibility you are currently pregnant? （ NO ・ YES ）

■ If you take any regular medicine, please list them below. (Please show us your medicine notebook if you have one)

_____

■ Do you have a primary care hospital/clinic?

_____

■ Do you smoke?

YES ・ Used to smoke (/day × years）

NO

■ Do you drink alcohol?

NO ・ YES ⇒ If YES, write down the amount you drink in 1 day.

Example： 2 glasses of wine/2 times a week （_____）

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■ Do you have any family members with the following diseases?
If yes, circle the diagnosis and specify the family member's relationship to you in the (　　).

Example: High blood pressure （ Mother ）

High blood pressure（　　）・ Cardiac disease （　　）・ Diabetes（　　）・ Stroke （　　）
Cancer （　　）・ Psychiatric disorder （　　）・ Asthma （　　）・ Other （　　）

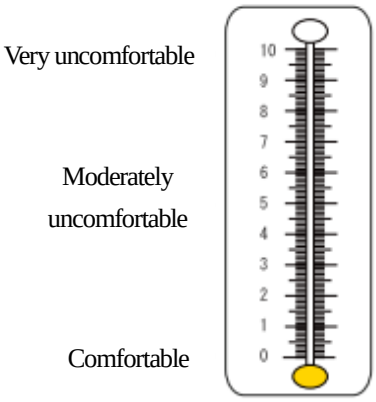
■ Tell us your height and weight

Height: cm/ft.　　Weight kg/lb

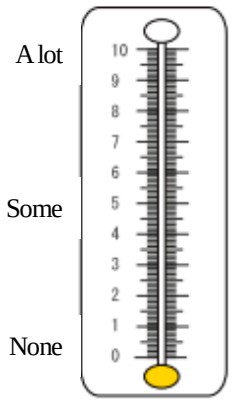
■ Do your symptoms interfere with your daily activities?

Discomfort and Interference Scale

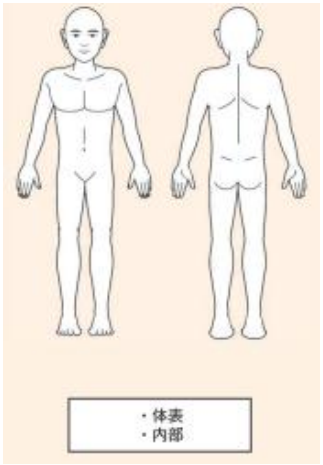
2. Please circle the average degree of discomfort you felt this week.



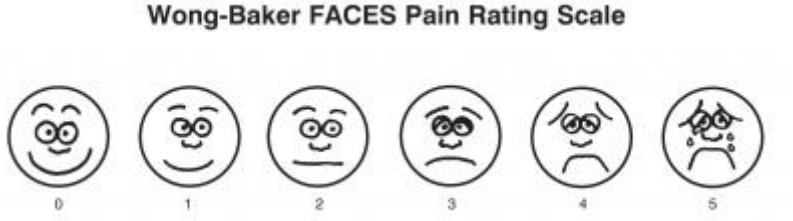
1. Was there any interference to your daily activities due to this discomfort?



■ Do you currently feel pain in your body? （Please circle the area and the appropriate level of pain below.）



（From the McGill Pain Questionnaire）



Thank you for answering the questionnaire.

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