# Patients Visiting the Cardiology/Cardiovascular Surgery Department

| Name: | Age: | Patient ID Number: |
|---|---|---|
| Phone Number (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) An abnormality was found on my electrocardiogram at my health checkup/I have had occasional chest tightness for the past year/I have been feeling out of breath when walking for the past 2-3 days, etc.

_____

_____

_____

■ Have you ever been diagnosed with any illnesses? Have you ever been hospitalized or undergone surgery?

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 medication record if you have one)

_____

■ Do you have a primary care hospital/clinic?

_____

■ Do you smoke?

YES ・ Used to smoke (_____ cigarettes/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 (_____)

**Continues on the back**

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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 parentheses.
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/lbs.

■ Please answer the below regarding your **mental state**.

(1) Please circle the amount of pain you currently have, with 10 being the worst pain you can imagine.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst pain ever

(2) Please circle the below number that best averages how difficult the past week has been for you.

0 1 2 3 4 5 6 7 8 9 10

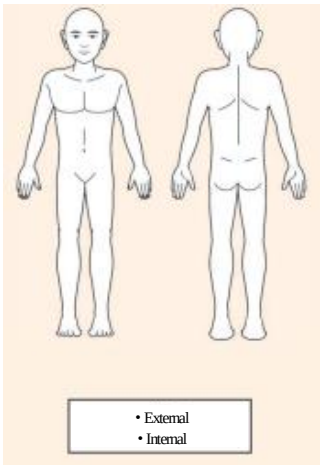
Not at all Extremely

(3) To what extent did that difficulty affect your daily life?

0 1 2 3 4 5 6 7 8 9 10

Not at all Extremely

■ 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 this questionnaire.**

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