

Duke Cardiology of Raleigh Follow-Up Questionnaire

Please complete this form. This information will help us to address your health issues during your visit.

Name _____ Today's Date _____ Date of birth _____

Name of your primary or referring doctor and his/her location _____

Is this visit because of a change in your health? Yes No

Since your last visit:

1. Your heart condition and symptoms have Improved Stayed same Worsened

2. Your activity level has Improved Stayed same Worsened

3. Have you been hospitalized? Yes No
If yes, when and at what hospital? _____

If yes, for what problem were you hospitalized? _____

Women Only:

Since your last visit, have you gone through menopause? If yes, when? _____

Have you been on Hormone Replacement Therapy? Yes No

Have you been pregnant since your last visit? Yes No

Do you need Medication refills? Yes No

Please list all medications you are currently taking, including the dosage and frequency.

Is there pain associated with this visit? If so, please circle level of pain, no pain being 0, extreme pain being 10.

0 1 2 3 4 5 6 7 8 9 10

Please check all that apply regarding your CURRENT symptoms:

- | | | | | |
|--------------|---------------------|-----------------|-------------|---------------------|
| Chest pain | Shortness of breath | Palpitations | Lightheaded | Fainting |
| Cough | Sputum production | Wheezing | Snoring | Swelling |
| Constipation | Abdominal pain | Blood in stools | Diarrhea | Nausea/vomiting |
| Headache | Seizure | Paralysis | Tremor | Abnormal walking |
| Bruising | Bleeding | Rash | Leg pain | Swollen lymph nodes |
| Fever | Chills | Weight loss | Weight gain | Poor appetite |

Signature
