North Lake CARDIOVASCULAR CENTER

Ahmed Hashim, MD, FACC, FSCAI
Cardiac and Vascular Diseases
Interventional and Nuclear Cardiology
310 South Greenleaf Street, Suite 212
Gurnee, IL 60031
Tel: 847.360.1000
Fax: 847.360.1001

General Health Questionnaire

Today's Date: _____

Name: _____ **Date of Birth** _____

What are the health concerns that brought you to see the doctor?

_____

Who is your primary care doctor?: _____

Who is the referring Doctor ? _____

	Yes	No
General		
1. Have you gained /lost more than ten pounds in the past six months?	_____	__ ___
2. Do you have frequent, mild, or severe headaches?	_____	_____
3. Has a doctor said you have glaucoma?	_____	_____
4. Have you ever had short spells of blindness?	_____	_____
Nose		
5. Do you have problems with a bloody nose?	_____	_____
Mouth/Throat		
6. Do you have bleeding gums?	_____	_____
7. Have you ever had radiation treatments or x-ray treatments to your Head , neck or chest?	_____	_____
Cardio Respiratory		
8. Do you have a cough or raise phlegm?	_____	_____
9. Have you ever coughed up blood?	_____	_____
10. Have you had: Asthma?	_____	_____
Bronchitis?	_____	____
Emphysema?	_____	_____
Pneumonia?	_____	_____
11. Do you become short of breath after climbing on flight of stairs?	_____	_____
12. Do you ever awaken at night short of breath?	_____	_____
13. Any history of sleep apnea? If yes, do you use a C-Pap machine?	_____	____
14. Has a doctor said that you had high blood pressure?	_____	_____
15. Has a doctor said that you had a heart murmur?	_____	_____
16. Have you ever had a heart attack?	_____	_____

17. Have you ever had rheumatic fever? _____ _____

18. Do you have pain or pressure or a tight feeling in your chest when
You are angry, excited, or working hard? _____ _____
19. Have you had racing or thumping of the heart? _____ _____
20. Do your ankles swell at the end of the day? _____ _ _____
21. Do you get calf or leg pain when you walk? _____ _____

GI

22. Do you have heartburn, indigestion, or pain in your stomach? _____ _____
23. Has a doctor told you that you had colon or bowel disease? _____ _____
24. Have you had any blood in your bowel movements? _____ _____
25. Has a doctor told you had liver disease (such as hepatitis)? _____ _____
26. Have you had any yellowing jaundice (yellowing of the eyes or skin)? _____ _____

GU

27. Have you ever passed bloody or dark brown urine the color of coffee? _____ _____

Bone and Joint

28. When your fingers get cold, do they become numb, hurt, or change color? _____ _____
29. Have you had any arthritis or rheumatism of the joint or gout? _____ __

Metabolism

30. Has a doctor told you that you have diabetes (sugar)? _____ _____
31. Has a doctor told you that you have thyroid disease or a goiter? _____ _____
32. Have you ever been told you have elevated or high cholesterol? _____ _____

Blood

33. Has a doctor told you that you have anemia (low blood count)? _____ _____
34. Has a doctor ever told you that you have a bleeding disorder? _____ _____
35. Has a doctor ever said you have cancer or a tumor? _____ _____
36. Have you ever had problems with excessive bleeding? _____ _____

Nero

37. Have you ever lost consciousness (been knocked out) or fainted? _____ _____
38. Have you ever had epilepsy or seizures? _____ _____
39. Has a doctor ever told you that you had a stroke? _____ _____
40. Do you have numbness or weakness in an arm or leg? _____ _____
41. Do you think you are experiencing problems with your memory? _____ _____

Habits/Health Maintenance

42. Have you ever smoked cigarettes? _____ _____
If yes, how many packs per day? _____How many years have you smoked? _____ _____
43. Do you exercise two or more times per week? _____ _____

44. When was the last tetanus booster? _____
45. Have you had any exposure to chemicals or toxins? _____ _____

Family History

Has anyone in your immediate family ever been diagnosed with:

Heart Attack? Yes___ No ___ If yes, which family member? _____
At what age? _____

Stroke? Yes ___ NO ___ If yes, which family member? _____

Diabetes? Yes ___ No ___ If yes, which family member? _____

High Blood Pressure? Yes ___ No ____ If yes, which family member? _____

Cancer? Yes ____ No ___ If yes, which family member? _____
What type? _____

Past Medical History

Have you been hospitalized for any reason in the past two years? Yes____ No ___ Date: _____

Have you had any surgeries in the past five years? Yes___ No ___ Date: _____

If yes, for what reason did you have surgery? _____

Are you currently taking medications?
If yes, please list them below:

_____
_____
_____
_____

Patients Signature: _____Date: _____

Provider Signature: _____Date: _____