Washington Adult Congenital Heart
First Patient Visit Questionnaire for Women

Version: 09/15/17

Part A: Patient Information

Name: _____

Date of Birth (MM/DD/YYYY): ___ ___/___ ___/___ ___ Phone Number: _____

Date of Visit (MM/DD/YYYY): ___ ___/___ ___/___ ___ Email Address: _____

Part B: Health Questionnaire

Please let us know in what way we can best assist you:

_____

Medical History: Please list all current and prior illnesses, injuries, operations, and hospital stays you can remember. Feel free to continue on the back of this page.

_____

_____

Do you have a Primary Care Provider/General Practitioner?

No ☐ If No, why not?_____

Yes ☐ If Yes, Date of last Primary Care visit_____ **Primary Care Provider name:**_____

Approximate weight 5 years ago:_____ Current weight:_____

How much time (at work or school) have you lost in the last 6 months from illness or injury? _____

Drug Reactions: Please list any drugs you have taken that have caused or been associated with a reaction and what kind of reaction.

Drug	Reaction	Drug	Reaction
_____		_____	
_____		_____	

Seasonal, Environmental Food, Herb or Supplement Allergy and Type of Reaction:

_____

Family History:

	If Living, Age & Health	**If Deceased, Age & Cause**
Father		
Mother		
Siblings		
Spouse/Partner		
Children		

Any diseases which "run" in your Family?:_____

Has any close blood relative ever had:

Disease/condition	Type	Relationship
Cancer		
Diabetes		
Allergic Tendency		
Heart Disease		
Elevated Cholesterol/lipids		
Colon Polyps/Colon Cancer		
Osteoporosis/Osteopania		

Personal History:

With whom do you share your home? Spouse Children Partner Pets Other None

Diet and Nutrition:

Do you now or have you ever followed any special diets? □ Y □ N If yes, what diet/plan?_____
Any foods you tolerate poorly or are allergic to?_____
Average number of meals per day: _____
How many glasses of water do you drink each day?_____
Do you:

Skip meals? □ Y □ N If yes, why?_____
Drink milk? □ Y □ N
Drink caffeine (coffee, tea, soda, etc.)? □ Y □ N If yes, avg amount/day:_____

In an average week, how often do you eat:

Red meat? _____
Poultry? _____
Fish? _____
Fruit? _____ servings per day_____
Vegetables?_____ servings per day_____

Do you:

- **Smoke?** □ Y □ N If yes, how much _____How Long _____
  - Did you ever smoke? □ Y □ N How much _____ When stopped_____
- **Drink alcohol?** □ Y □ N
  - If yes, please describe average amount /wk _____
  - Has anyone ever told you that you should cut down? □ Y □ N
- **Drink energy drinks** (i.e., Redbull, Monster, 5-hour Energy etc)? □ Y □ N
  - If yes, please describe average amount /wk _____
- **Use Marijuana / other substances?** □ Y □ N
  - If yes, please describe type & average amount /wk _____

Exercise, Relaxation & Wellbeing:

Do you have any form of regular or occasional exercise program? □ Yes □ No

If yes, what kind of exercise do you do?_____

How often do you exercise? _____
For how long do you exercise?_____
What do you do to relax? _____

Do you practice meditation or yoga for stress relief?
□ Yes □ No

If not, would you like more information?
□ Yes □ No

Over the past two weeks, have you been bothered by these problems?	**Not at all**	**Several days**	**More days than not**	**Nearly every day**
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Feeling down, depressed or hopeless				
Little interest or pleasure in doing things				

Over the last week, how much have you been bothered by:

	Not at all			a little			moderately			severely
Feeling stressed	0	1	2	3	4	5	6	7	8	9
Feeling angry	0	1	2	3	4	5	6	7	8	9
Not having the social support you feel you need	0	1	2	3	4	5	6	7	8	9

The thought of harming myself has occurred to me. □ Y □ N
Have you ever been a victim of abuse? □ Y □ N
Have you ever been advised to be or been under psychiatric care or other counseling? □ Y □ N

Average number of hours you sleep each night _____
□ Recent Change in sleep pattern
□ Trouble falling into sleep
□ Trouble waking early, unable to fall back asleep
□ Feel rested when awake each morning
□ Tired much of the time

Please let us know more about your plans for your future health care:
□ I have a Living Will
□ I have set up a Durable Power of Attorney for Health Care
□ I have discussed my wishes for ultimate [end-of-life] health care with my family

If you do not have plans for your future health care, please tell us why?
□ I don't know what this is
□ I don't have time to set these things up
□ I don't know where to start
□ Other_____

Education - please circle highest completed :
1. Grades 1 -8
2. Some High School
3. High School
4. Some College
5. Associates Degree
6. Bachelors Degree
7. Masters Degree
8. Other advanced Degree

Race – please circle
1. White
2. Black
3. Asian
4. Hispanic/Latino
5. American Indian
6. Hawaiian
7. Other
8. Decline to answer

Follow-up Visit in _____ Months

Please check off any of the following issues *you have had or currently have since your last visit*:

Gynecological:

Frequency of Periods:
____-day cycle, ___ days of flow
Periods are: Light Moderate Heavy
Timing is: Regular Irregular
□ Recent change in periods?
□ Last Menstrual Period _____
□ Premenstrual symptoms _____
□ Do you use Birth Control?
Type_____
□ Painful intercourse

□ Pregnancies:
Number _____
Deliveries ____
Complicated Pregnancies _____
□ Hot flashes /other menopausal symptoms
When started _____
□ Have periods stopped completely?
If so, at what age _____
□ Fibroids, endometriosis, ovarian cysts
□ Pelvic Inflammatory Disease
□ Abnormal vaginal discharge
Gynecologist name:_____
Date of Last Pap Smear _____ Normal? Y N
□ History of Abnormal Pap Smear?
Abnormal in what way _____
Treatment _____
Follow-up _____

Breasts:

□ Perform regular breast self-exams?
Any abnormalities _____
□ When was your last mammogram?_____
Any abnormalities? _____
□ History of breast biopsies?
Findings _____

Head:

□ Eye disease or injury
□ Double vision
□ Wear glasses or contacts
Correction required to drive?____
□ Eye Surgery/Correction
□ Glaucoma
Last tested for Glaucoma _____
□ Hearing troubles, Ringing in Ears, Ear Disease
□ Troubles with Vertigo (Room seems to spin)
□ Nose Bleeds
□ Trouble breathing through your nose
□ Sinus troubles or infections
□ Severe Dizziness
□ Seizures or Convulsions

Neck:

□ Thyroid Ailment
□ Neck Arthritis, Neck Surgery or Neck Chiropractic Problem
□ Swelling of the neck or Lymph Nodes

Respiratory:

□ Chronic cough (including "smokers cough")
□ Do you cough up phlegm? Y N
If Yes, what color is it? _____
□ Spitting or coughing of blood
□ Shortness of breath
□ Asthma or wheezing
□ Night sweats
□ Skin tests for Tuberculosis
Last done _____ Positive? Y N
□ Year of Last Chest X Ray _____
Was it Normal? Y N

Cardiovascular:

□ Angina, chest pain or pressure
□ Shortness of breath when lying down
□ Ankles or legs swelling
□ Rapid, hard or skipped Heart Beat
□ Are you supposed to take antibiotics before dental work?

Dental:

□ Wear dentures
□ Gum disease /gingivitis
□ Floss regularly
□ Regular teeth cleaning
Last visit _____
□ Dental extractions

Gastrointestinal:

□ Ulcer history
□ Heartburn or indigestion
□ Often use antacids
□ Trouble swallowing / foods sticking in throat

□ Intolerance to foods
□ Gallbladder trouble
□ Do you often vomit?
□ Ever vomit blood?
□ Crampy abdominal pains
□ Any liver trouble
□ Chronic constipation
□ Frequent diarrhea
□ Recent change in bowel habits
□ Hemorrhoids or Piles
Require/required surgery? Y/N
□ Use Laxatives
Bowel Movement Frequency per Week _____

Genitourinary:
□ Loss of urine when cough or sneeze
□ Kidney or bladder infections
□ Feeling that you must go constantly
□ Blood in urine
□ Kidney stones
□ Difficulty in starting urination
□ Get up at night to urinate?
How Often _____
□ Are you experiencing any of the following symptoms of sexual dysfunction?
Low sexual desire/interest in sex_____
Difficulties with sexual arousal_____
Pain with intercourse_____

Musculoskeletal:
□ Arthritis
Type if known _____
□ Weakness which is new or limits what do you
□ Unexplained muscle pains
□ Difficulty in walking
□ Pain in calves or buttocks on walking
Relieved at rest? Y N

Skin:
□ Frequent Skin Infections
□ Skin Diseases
What kind? _____
□ History of increased sun exposure, or frequent prior sunburns
□ Wear sun screen and protective clothing when sun exposed
□ Date of Last Dermatology Visit_____
Doctor:_____ _____
□ History of removal of skin lesions
Type: _____

Blood Disorders:
□ History of anemia
When _____
□ Excessive bleeding or bruising
When _____
□ Date of last blood test _____
Any abnormalities? Y N