CVIC
Cardiovascular Imaging Clinic

CVIC Patient Questionnaire

CVIC ID :

Name		Gender	Male | Female
Date of Birth(DOB)	Year / month / day	Occupation	

1 Have any relatives had heart disease? 〔 Yes | No 〕
〔 Grandfather | Grandmother | Father | Mother | Brother | Sister 〕
Have any relatives died suddenly? 〔 Yes | No 〕

2 Have you ever been told that you have the following conditions?
〔 High blood pressure | High cholesterol | High triglycerides | Diabetes 〕
Are you taking medication for any of the above conditions? 〔 Yes | No 〕

3 Have you been diagnosed with any of the following diseases? 〔 Yes | No 〕
〔 Heart attack | Angina | Irregular heartbeat | Valvular disease | Congenital disorder |
Pulmonary embolism | Deep vein thrombosis | Brain disease | Kidney disease | Glaucoma |
Asthma (☐Current | ☐Childhood only) 〕

4 Have you undergone any heart surgery or procedures? 〔 Yes | No 〕
〔 Cardiac catheterization | Prosthetic valves | Pacemaker insertion | Stent treatment |
Aneurysm of aorta | Arrhythmia | Other : 〕

5 Do you have a history of allergic reactions? 〔 Yes | No 〕
〔 Pollen | Medication | Food | Other: 〕

6 Do you smoke? 〔 Yes | No 〕
〔 If yes, how many cigarettes per day? ____ | If you quit, how many years ago did you quit
and how many cigarettes did you smoke per day? ____ 〕

7 Do you consume alcohol? 〔 Everyday | Sometimes: mL/day | No 〕

8 Do you exercise regularly? 〔 Yes | No 〕
〔If yes, what type of exercise? : ________________ Frequency :____times per month / week / day〕

9 Do you have claustrophobia (fear of enclosed spaces)? 〔 Yes | No 〕
Do you have any metals in your body? 〔 Yes | No 〕
〔 Implant | False tooth | Stent | Other : 〕

10 Do you experience chest pain, tightness, or difficulty breathing? 〔 Yes | No 〕
If yes, please provide more details Onset: ______________________
・Frequency: 〔 ____ times per month / week / day 〕
・Severity: 〔 Mild | Moderate | Severe 〕
・Description: 〔 Pressure | Heaviness | Tightness | Tingling | Pounding | Prickling 〕
・Time of occurrence: 〔 Early morning | Morning | Afternoon | Midnight | Anytime 〕
・When does it occur: 〔 During exercise | During rest | Both 〕
・Is it worsening recently? 〔 Yes | No 〕
Do you experience any of the following symptoms? 〔 Yes | No 〕
〔Pain in left shoulder | Pain in left arm | chin/teeth ache | cold sweat | Muscle weakness 〕

11 Sleep.
Usual bedtime : ________ Usual wake-up time : ________
Quality of sleep : 〔 Good | Average | Poor 〕

12 * For females: Have you gone through menopause? 〔 Yes | No 〕
Are you currently pregnant? 〔 Yes | No 〕

13 Other concerns or worries :