Royal Brompton and Harefield
Heart and lung care

Cardiac Care Questionnaire

Private and Confidential

Please complete the questionnaire prior to your appointment and return via email, privatepatients@rbht.nhs.uk or post to the relevant hospital. If completing online simply click on the check boxes to cross and click on the grey form fields to input text.

Royal Brompton Hospital
Heart Risk Clinic, Private Consulting Rooms,
Royal Brompton Hospital, Sydney Street,
London SW3 6NP

Harefield Hospital
Heart Risk Clinic, Private Consulting Rooms,
Harefield Hospital, Hill End Road,
Harefield UB9 6JH

The information will help us assess your current state of health and ensure that we carry out the appropriate tests. If you have any concerns regarding any of the questions within this form, please contact our Private Patients Departments and request to speak to a member of the nursing team: **Brompton Hospital** 0207 351 8828 or **Harefield Hospital** 0189 582 8857

Patient information

Hospital number:	Contact Tel: .....
Title: ..... Surname:	Mobile No.: .....
Forename(s):	Email: .....
Address:	Interpreter required: ☐ Yes ☐ No
.....	Language: .....
.....	Nationality and Ethnicity: .....
Postcode:	Allergies: .....
Date of birth: .... / .... /	Current weight (kg): .....
Gender: ☐ Male ☐ Female	Current height (cm): .....

Marital status: ☐ Single ☐ Married / Civil Partnership ☐ Divorced ☐ Windowed

Current Symptoms	Date occurred	Yes	No	Unsure
1. Do you get chest discomfort?	.... / .... /	☐	☐	☐
If yes:				
- is it brought on by physical effort?	.... / .... /	☐	☐	☐
- does it occur in the front of your chest?	.... / .... /	☐	☐	☐
- does it occur around your neck, jaw or shoulder?	.... / .... /	☐	☐	☐
- is it relieved by rest or GTN (glyceryl trinitrate) spray?	.... / .... /	☐	☐	☐

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2. Do you get unnaturally breathless when walking? If yes: - how far can you walk before getting breathless? - is this at normal or fast pace? ..... - do you suffer from asthma / bronchitis?	..... / ..... / .... / ..... / .... / ..... / .... / ..... /	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
3. Do you get breathless when lying flat? If yes: - do you have to sleep propped up? - if yes, how many pillows do you sleep on? ..... - do you wake up to catch up with breathing? - do your ankles get swollen?	..... / ..... / .... / ..... / .... / ..... / .... / ..... / .... / ..... /	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
4. Have you ever suffered from palpitations? If yes: - do they make you feel unwell? - do they last less than 5 minutes? - how long have you been experiencing them?	..... / ..... / .... / ..... / .... / ..... / .... / ..... /	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Cardiac History:	**Date occurred**	**Yes**	**No**	**Unsure**
5. Have you ever been diagnosed with a heart condition? If yes, what?	..... / ..... /	☐	☐	☐
6. Have you ever had a heart attack?	..... / ..... /	☐	☐	☐
7. Have you ever had a coronary angiogram?	..... / ..... /	☐	☐	☐
8. Have you ever had a coronary angioplasty?	..... / ..... /	☐	☐	☐
9. Have you ever been told you have a heart murmur? If yes, have you seen a health care professional?	..... / ..... / .... / ..... /	☐ ☐	☐ ☐	☐ ☐
10. Have you ever had rheumatic fever?	..... / ..... /	☐	☐	☐
11. Have you ever been diagnosed with high blood pressure?	..... / ..... /	☐	☐	☐
12. Have you ever had a cardiac stent inserted?	..... / ..... /	☐	☐	☐

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13. Have you ever had kidney problems? If yes, when did you last have blood tests to check them?	..... / ..... /	☐	☐	☐
14. Do you have other medical conditions? If yes, please list here:				
15. Please list any medicines/supplements you are currently taking, or attach a copy of your prescription:				

Cardiac Risk Factors:	**Yes**	**No**	**Unsure**
16. Do you smoke? If yes, how many a day?	☐	☐	☐
17. Have you smoked in the past? If yes, how many a day? ..... When did you give up? ..... / ..... /	☐	☐	☐
18. Do you have high cholesterol? If yes, do you take tablets for your cholesterol?	☐ ☐	☐ ☐	☐ ☐
19. Do you suffer from high blood pressure? If yes, do you take tablets for your blood pressure?	☐ ☐	☐ ☐	☐ ☐
20. Do you have diabetes? If yes, what treatment do you have? (i.e. diet, tablets, insulin)	☐	☐	☐
21. Do you exercise on a regular basis? If yes, what form of exercise, and how many hours per week?	☐	☐	☐

Family History:	**Yes**	**No**	**Unsure**
22. Have any of your close relatives (i.e. mother, father, brother or sister) died of a heart condition?	☐	☐	☐

If yes:

Relative ..... Age at time of death: ..... Cause of death .....

Relative ..... Age at time of death: ..... Cause of death .....

23. Have any of your close relatives (i.e. mother, father, brother or sister), alive or dead, suffered from the following:	**Yes**	**No**	**Unsure**
- Coronary heart disease	☐	☐	☐
- CVA/stroke	☐	☐	☐
- Aortic aneurysm (burst aorta)	☐	☐	☐

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- Type two diabetes - Bowel cancer	☐ ☐	☐ ☐	☐ ☐

Social History:	**Yes**	**No**	**Unsure**
24. Do you drink more than 14 units of alcohol per week? (A small glass of wine (125ml) is approx. 1.5 units, an average strength pint of larger approx. 2 units and a measure of spirits 1 unit)	☐	☐	☐
25. Do you binge drink? (for men this means more than 8 units/session, for women this means more than 6 units/session) If yes, how many times a week?	☐	☐	☐
26. Have you ever taken any recreational drugs? If yes, what and when?	☐	☐	☐
27. What is your current occupation?			
28. What are your hobbies?			

Nutritional History:	**Yes**	**No**	**Unsure**
29. Are you a vegetarian?	☐	☐	☐
30. Have you had any weight problems? If yes, were you referred to a healthcare professional?	☐ ☐	☐ ☐	☐ ☐
If you were assessed and are aware of the below please provide details: Past: ☐ Over recommended weight by ..... kg ☐ Under recommended weight by ..... kg Present: ☐ Over recommended weight by ..... kg ☐ Under recommended weight by ..... kg			
31. Have you had any dietary disorders? e.g. irritable bowel, intolerances or allergies If yes, were you referred to a healthcare professional? (please explain) Past: ..... Present:	☐	☐	☐

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FOR MEN:	**Yes**	**No**	**Unsure**
32. Have you experienced erectile dysfunction (the inability to attain and maintain an erection sufficient for sexual intercourse)? If so, how often?	☐	☐	☐
FOR WOMEN - Menstruation History:	**Yes**	**No**	**Unsure**
33. At what age did you begin menstruating?			
34. What was the date of your last menstrual period? ..... / ..... /			
35. Have you ever been pregnant? If yes, how many times?	☐	☐	☐
36. Did you suffer with high blood pressure during pregnancy?	☐	☐	☐
37. Did you suffer with diabetes during pregnancy?	☐	☐	☐
38. Have you a history of 2 or more miscarriages? If yes, how many?	☐	☐	☐
39. Is there a possibility you may be pregnant?	☐	☐	☐
40. Are you planning to become pregnant in the future?	☐	☐	☐
41. What form of contraception do you currently use? ..... How long have you been using this contraception?			
42. Have you ever had any fertility treatment?	☐	☐	☐
43. Did your mother go through the menopause? If yes, at what age did her symptoms begin?	☐	☐	☐
44. Have you gone through the menopause?	☐	☐	☐
45. Was this confirmed by a healthcare professional?	☐	☐	☐
46. Do you still experience menopausal symptoms?	☐	☐	☐
47. What age do you consider your menopausal symptoms began?			
48. What age did your menstruation cease?			

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Please sign/type name to confirm you have completed the form: .....

If you have completed the form on behalf of the patient please provide your name:

.....

Date: .... / .... / .....

How did you hear about our services? .....

Word of mouth ☐ GP ☐ Internet ☐ Advertisement ☐ Press article ☐

Other (please specify) .....

STAFF ONLY:

Date questionnaire received: .... / .... / .....

Patient contacted: .....

Appointment date: .... / .... / .....