



PRE-ADMISSION PATIENT SCREENING QUESTIONNAIRE FOR CARDIAC RISK

Patient Name:	Date of Birth:	
Diagnosis:	Surgical Procedure:	
Primary Care Provider Dr.:	Phone:	
Do you have a cardiologist? Yes <input type="checkbox"/> / No <input type="checkbox"/> If Yes: who?: _____ Phone: _____ If Yes: do they know about this current condition that may required surgery? Yes <input type="checkbox"/> / No <input type="checkbox"/>		
<i>Please be advised that depending on your history we may ask you to see your cardiologist prior to surgery and in higher risk cases, we may ask for you to consult with a Stony Brook affiliated cardiologist, who would be able to help with your care while you are in our hospital.</i>		
Section 1:		
1. Have you ever been told you have an abnormal ECG?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Do you have an irregular heartbeat (such as "afib") or heart rhythm problem? <i>If yes, please explain:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Do you have a heart murmur, mitral valve prolapse, or any other heart valve problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Do you have chest pain with walking/normal activity or with exercise?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you ever had a heart attack? <i>If yes, how many?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Do you have a weak or failing heart (congestive heart failure, CHF)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Do you ever have shortness of breath with walking 1 or 2 flights of stairs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Have you ever had blockages in the arteries of your neck, heart or legs or been told you have peripheral vascular disease (PVD)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Have you ever had a stroke (CVA), mini stroke (TIA) or brain attack? <i>If yes, when?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm or aortic dissection?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Were you born with any heart lesions, holes in the heart, etc.?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Do you have pulmonary hypertension?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you ever had a stress test? <i>If yes, where?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. Have you ever had a cardiac echo cardiogram? <i>If yes, where?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Have you ever had a heart catheterization? <i>If yes, where?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Have you ever had a heart valve replacement or repair? <i>If yes, where?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Do you have a pacemaker or defibrillator?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Do you have a heart stent? <i>If yes, how many?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Have you ever had a coronary bypass surgery or angioplasty? <i>If yes, where?:</i> <i>When?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>



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Section 2:			
1. Do you have or are you being treated for high blood pressure? <i>If yes, how many years?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. Do you have diabetes? <i>If yes, for how many years?; _____ Type: _____</i> <i>Complications?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
3. Do you use an Insulin Pump?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
4. Are you a former or current smoker? <i>If yes, for how long?:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
5. Do you have high cholesterol or take a "Statin" medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
6. Do you lead a sedentary lifestyle (exercise less than 2 times a week)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
7. Do you have a clotting disorder? <i>If yes, explain:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
8. Do you have any other major medical problems that we have not asked you about? <i>If yes, specify:</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Section 3:			
Do you take any of the following medications: If yes, what dose?			
<input type="checkbox"/> Aspirin (acetylsalicylic acid)	Dose:	<input type="checkbox"/> Advil (ibuprofen)	Dose:
Antiplatelets:	<input type="checkbox"/> Plavix (clopidogrel)	<input type="checkbox"/> Effient (prasugrel)	Dose:
	<input type="checkbox"/> Brilinta (ticagrelor)	<input type="checkbox"/> Other:	
Anticoagulation:	<input type="checkbox"/> Coumadin (warfarin)	<input type="checkbox"/> Lovenox (enoxaparin)	Dose:
	<input type="checkbox"/> Pradaxa (dabigatran etexilate)	<input type="checkbox"/> Xarelto (rivaroxaban)	
	<input type="checkbox"/> Eliquis (apixaban)	<input type="checkbox"/> Other:	
OFFICE USE:			
Not Intended for: Age <40 (unless known Cardiac/Vascular history) or Cases using only light sedation or local anesthetic			
Referral made for:	<input type="checkbox"/> 1) ACS NSQIP Calculator Risk >1% <input type="checkbox"/> 2) Presence of one check box in first section, or <input type="checkbox"/> 3) Presence of two or more risk factors in the second section		
<input type="checkbox"/> Stony Brook Medicine University Physicians 26 Research Way, E. Setauket NY 11733, Phone: 631-444-0580 or 444-9615, Fax: 631-444-0562 200 Motor Parkway Suite C-16, Hauppauge NY 11788, Phone: 631-444-9600, Fax: 631-444-9621			
<input type="checkbox"/> North Suffolk Cardiology 45 Research Way, Suite 108, E. Setauket 11733, Phone: 631-941-2000, Fax: 631-941-2010			
<input type="checkbox"/> Eastern Suffolk Cardiology 951 Roanoke Ave, Riverhead NY 11901, Phone: 631-727-7773, Fax: 631-727-7832			
<input type="checkbox"/> Heart Associates of Long Island 220 Belle Mead Rd, E. Setauket NY 11733, Phone: 631-941-2273, Fax: 631-941-2501			
<input type="checkbox"/> Patient's Cardiologist or Other			