

Heart Examination Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/____

1. Are you aware of the patient having any history of the following conditions? | Yes No
 If yes, please indicate which of the following apply to this client:

- | | | | |
|--|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Cardiac insufficiency | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Cardiomegaly |

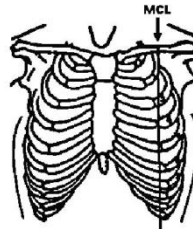
If yes, please provide details: _____

2. Was a heart murmur detected during this examination? | Yes | No
 If yes, complete the following:

a) Timing	<input type="checkbox"/> systolic	<input type="checkbox"/> presystolic	<input type="checkbox"/> diastolic	<input type="checkbox"/> other: _____		
b) Grade	<input type="checkbox"/> 1/6	<input type="checkbox"/> 2/6	<input type="checkbox"/> 3/6	<input type="checkbox"/> 4/6	<input type="checkbox"/> 5/6	<input type="checkbox"/> 6/6
c) Character	<input type="checkbox"/> soft	<input type="checkbox"/> blowing	<input type="checkbox"/> harsh	<input type="checkbox"/> other: _____		
d) How is murmur affected with inspiration?	<input type="checkbox"/> disappears	<input type="checkbox"/> no change	<input type="checkbox"/> other: _____			
e) How is murmur in a lying position?	<input type="checkbox"/> disappears	<input type="checkbox"/> no change	<input type="checkbox"/> other: _____			
f) How is murmur in an upright position?	<input type="checkbox"/> disappears	<input type="checkbox"/> no change	<input type="checkbox"/> other: _____			
g) How is murmur while exercising?	<input type="checkbox"/> disappears	<input type="checkbox"/> no change	<input type="checkbox"/> other: _____			
h) Symptoms	<input type="checkbox"/> none	<input type="checkbox"/> dyspnea	<input type="checkbox"/> cyanosis	<input type="checkbox"/> edema	<input type="checkbox"/> arrhythmia	<input type="checkbox"/> hypertension
	<input type="checkbox"/> other (specify): _____					

Indicate the following on the diagram:

- Area of apex by an "X"
- Point of maximum intensity by an "O"
- Murmur area by a "□"
- Direction of transmission by a "⇒"



3. Please provide us with the following information. If it is not applicable, please indicate N/A.

Test	Date	Result (please provide us with a copy, if available)
ECG	_____	_____
Echocardiogram	_____	_____
Other (specify) : _____	_____	_____

4. What is your diagnosis? _____

Name of Attending Physician (print) _____ Attending Physician's Signature _____ Date (DD/MM/YYYY) _____