Biographical Questionnaire

1. **Name: …….**
2. **Date of Birth: ……..**
3. **Do you have a history of:**
   - a. **Diabetes** **Yes** **No**
   - b **High Blood Pressure** **Yes** **No**
   - c. **High Cholesterol** **Yes** **No**
4. **Do you have a family history of:**
   - a. **Heart attacks, Chest pain (angina)/Bypass Surgery Angiogram?** **Yes** **No**
   - b. **Strokes** **Yes** **No**
   - c. **Any other chronic illness** **Yes** **No**

   ……..
5. **Do you smoke?** **Yes** **No**

   If so, how many? ……..
6. **Have you ever been hospitalized ?** **Yes** **No**

   If Yes, then when ? ……..
7. **Have you had any operation?** **Yes** **No**

   If yes, then describe briefly ……

   ……
8. **Are you experiencing chest pain?** **Yes** **No**
   - **Daily ?** **Yes** **No**
   - **With exercise/walking?** **Yes** **No**
   - **Weekly ?** **Yes** **No**
9. **Do you have any allergies ?** **Yes** **No**
10. **Are you experiencing shortness of breath?** **Yes** **No**

    If yes how far can you walk (in meters)? …….
11. **Are you experiencing palpitations?** **Yes** **No**

    How frequently? …….
12. **Are you experiencing dizzy spells or have you fainted?** **Yes** **No**
13. **Weight: _____ Height: _____**
14. **Chronic Medication? ……**