Date of test: ___________ / ___________ / ___________

_________________________________________  First name ____________________________  Middle initial

Street address ____________________________  City ____________  State ___________  Zip code ___________

Home phone ( ) ______ - ______  Work phone ( ) ______ - ______  Cell Phone ( ) ______ - ______

Email: ___________________________________

Age: ________  Demographics: What is your ethnicity?
Sex:  □ Male  □ Female  □ African-American  □ Caucasian  □ Native-American
       □ Asian/Pacific Islander  □ Hispanic/Latino  □ Other [specify]: ___________ 

The following body measurements help in the interpretation of your test results:
Height: ___ inches  Weight: ___ pounds  Bra size/cup: ___ (eg. 34-B) Breast implants?  □ Yes  □ No
(Answer only if you are having a nuclear study)

Emergency contact information:

_________________________________________  First name ____________________________  Relationship
Home phone ( ) ______ - ______  Work phone ( ) ______ - ______
Cell phone ( ) ______ - ______  Email: ___________________________________

Physician information:

Primary physician: ____________________________________________ ( ) ______ - ______
                   Last name ____________________________  First name ____________________________  Fax number (required for non-Cedars MD)

Cardiologist: ____________________________________________ ( ) ______ - ______
             Last name ____________________________  First name ____________________________  Fax number (required for non-Cedars MD)

Physicians other than listed above to send copy of report:

_________________________________________  First name ____________________________  Fax number (required for non-Cedars MD)

_________________________________________  First name ____________________________  Fax number (required for non-Cedars MD)

MEDICAL HISTORY

1. Have you had any caffeine-containing beverages, foods, or medicines (including soda, energy drinks, coffee, decaffeinated coffee, tea, chocolate, cocoa, Excedrin, etc.) within the past 24 hours?
   □ No  □ Yes, please specify products: ____________________________

2. Have you ever been told you have asthma or other chronic respiratory disease?
   □ No  □ Yes, please specify name of condition: ____________________________
### MEDICAL HISTORY (continued)

3. Is this test being done as part of a **pre-op** evaluation for surgery?  
   - [ ] No  
   - [ ] Yes, please specify type of surgery: ____________________________

4. Are you allergic to **iodine contrast**?  
   - [ ] No  
   - [ ] Yes

### SYMPTOMS

**IMPORTANT:** If you have had bypass surgery, an angioplasty, or a heart attack in the last 12 months, only describe discomfort since then.

1. **CHEST PAIN / DISCOMFORT:**  
   Have you had any pain or discomfort above your waist in the last 12 months?  
   - [ ] No  
   - [ ] Yes

   If YES:
   
   a. Approximately how long have you had this pain or discomfort? ____________________________
   
   b. Does the pain/discomfort occur mostly in the center of your chest?  
      - [ ] No  
      - [ ] Yes
      
      If not, which of the following locations describe most of your discomfort?  
      - [ ] Left side of the chest  
      - [ ] Left arm  
      - [ ] Neck or Jaw  
      - [ ] Other, specify: ____________________________

   c. Does the pain/discomfort occur commonly with physical exertion?  
      - [ ] No  
      - [ ] Yes
      
      If Yes, does the pain/discomfort most often go away within 10 minutes with rest?  
      - [ ] No  
      - [ ] Yes

   d. Does the pain/discomfort go away with nitroglycerin?  
      - [ ] Never taken  
      - [ ] No  
      - [ ] Yes

   e. Has this pain or discomfort been getting worse **during the last month**?  
      (i.e. more often, more severe or intense, or lasting longer)  
      - [ ] No  
      - [ ] Yes

2. **SHORTNESS OF BREATH:**  
   Have you had any shortness of breath in the last 12 months?  
   - [ ] No  
   - [ ] Yes

   Do you have shortness of breath during physical exertion?  
   - [ ] No  
   - [ ] Yes

   Have you had worsening shortness of breath during the last month?  
   (i.e. more often, more severe or intense, or lasting longer)  
   - [ ] No  
   - [ ] Yes

3. **OTHER SYMPTOMS:**  
   Have you had any of the following in the last 12 months?  
   
   - Palpitations  
     - [ ] No  
     - [ ] Yes
   
   - Fainting, syncope (**blackouts**)  
     - [ ] No  
     - [ ] Yes
# CARDIAC HISTORY

1. Have you ever had the following:
   a. **HEART ATTACK** *(myocardial infarction)*?
      - [ ] No  [ ] Yes
      - Date of most recent [MM-DD-YY]: __________ - __________ - __________
      - Location [Hospital, City, State]: ________________________________
   b. **CARDIAC CATHETERIZATION** for a coronary angiogram?
      - [ ] No  [ ] Yes
      - Date of most recent [MM-DD-YY]: __________ - __________ - __________
      - Location [Hospital, City, State]: ________________________________
   c. **CORONARY ANGIOPLASTY** *(balloon or stent)*?
      - [ ] No  [ ] Yes
      - Date of most recent [MM-DD-YY]: __________ - __________ - __________
      - Location [Hospital, City, State]: ________________________________
   d. **CONGENITAL HEART DISEASE** *(problems with your heart chamber / valves, “holes” or “murmur” in the heart?)*
      - [ ] No  [ ] Yes
      - Describe type of congenital heart disease: ________________________________
   e. **HEART SURGERY**?
      - [ ] No  [ ] Yes
      - Date of most recent [MM-DD-YY]: __________ - __________ - __________
      - Location [Hospital, City, State]: ________________________________
      - What type of heart surgery did you have? Mark all that apply.
        - [ ] Bypass Surgery  [ ] Valve Surgery  [ ] Heart Transplant  [ ] Other: ________________________________
        - [ ] Congenital *(Describe repair): ________________________________
   f. Pacemaker?
      - [ ] No  [ ] Yes
   g. Defibrillator *(ICD)*?
      - [ ] No  [ ] Yes
   h. Coronary Calcium Scan? *(Coronary calcium score: __________)*
      - [ ] No  [ ] Yes

2. Have you ever been told by a health care practitioner that you have:
   a. High blood pressure *(hypertension)*
      - [ ] No  [ ] Yes
   b. High cholesterol
      - [ ] No  [ ] Yes
   c. Diabetes
      - [ ] No  [ ] Yes
   d. A heart valve problem
      - [ ] No  [ ] Yes
   e. A heart murmur?
      - [ ] No  [ ] Yes
   f. An irregular heartbeat *(arrhythmia)*
      - [ ] No  [ ] Yes
   g. Atrial flutter or fibrillation?
      - [ ] No  [ ] Yes
   h. Heart failure
      - [ ] No  [ ] Yes
   i. Stroke or TIA *(transient ischemic attack)*
      - [ ] No  [ ] Yes
   j. Renal *(kidney)* failure or dysfunction
      - [ ] No  [ ] Yes

3. Do you experience a cramping pain in your calves when you walk, which your doctor has called **peripheral arterial disease** or claudication?
   - [ ] No  [ ] Yes
4. Do you currently OR have you ever smoked cigarettes?  
   - No  
   - Yes
   - How many years did you smoke? _________
   - How many packs per day on average?  
     - Less than ½ pack  
     - ½ to 1 pack  
     - More than 1 pack
   - Have you stopped smoking?  
     - Yes, specify date stopped: _____ / _____ / _____  
     - No, did not stop smoking

5. Please list any other SERIOUS MEDICAL PROBLEMS:  
   - None

6. FEMALES:  
   - Are you POST MENOPAUSAL?  
     - No  
     - Yes
   - If YES, are you taking estrogen replacement?  
     - No  
     - Yes

**FAMILY HISTORY FOR HEART DISEASE**  
Do you have any close blood relative(s) who developed CORONARY HEART DISEASE before age 55 for male relatives or before 65 for female relatives? (i.e. child, parents, siblings, grandparents)  
   - No  
   - Yes, specify how many: _______  
   - Don’t Know

**EXERCISE AND DIET**  
Circle one number only that best answers each question.

   a. How much do you exercise?  
      - 0 NONE  
      - 1 ALWAYS

   b. How much does the status of your heart limit your day-to-day physical activities?  
      - 0 NONE  
      - 1 ALWAYS

   c. How much does the status of your heart limit your emotional well-being?  
      - 0 NONE  
      - 1 ALWAYS

   d. To what extent are you on a low saturated fat diet?  
      - 0 NONE  
      - 1 ALWAYS
MEDICATIONS

Are you taking any of the following medications? Check all that apply.

☑ Ace Inhibitors [ex: Captopril / Capoten, Quinapril / Accupril, Lisinopril / Zestril, Ramipril / Altace, Benazepril / Lotensin, Fosinopril / Monopril]
☑ Aspirin [ex: Bayer, Ecotrin]
☑ Coumadin or Warfarin
☑ Digoxin [ex: Digitalis]
☑ Insulin
☑ Nitroglycerin
☑ Nitrates [ex: Nitroglycerin, Nitroglycerin]
☑ Vitamin C
☑ Medications for chest pain
☑ ARBs [ex: Losartan / Cozaar, Hyzaar, Irbesartan / Avapro, Valsartan / Diovan, Telmisartan / Myocardis, Candesartan / Atacand, Olmesartan / Benicar, Eprosartan / Tevetan]
☑ Blood pressure lowering drugs
☑ Cholesterol lowering drugs
☑ Hormone replacement therapy [Females only]
☑ Oral diabetic medications [ex: Glucotrol, Actos, Glucophage / Metformin, Glyburide, Actose]
☑ Other platelet inhibitors [ex: Plavix, Clopidogrel, Aggrenox, Dipyridamole]
☑ Antioxidants
☑ Beta Blockers [ex: Acebutolol / Sectral, Atenolol / Tenormin, Betaxtol / Kerlone, Metoprolol / Lopressor, Carvedilol / Coreg, Propranolol / Inderal, Sotalol]
☑ Calcium Channel Blockers [ex: Nifedipine / Procardia, Diltiazem / Cardizem, Verapamil / Calan, Isoptin, Nicardipine / Cardene, Adalat, Felodipine / Plendil, Isradipine / Dynacirc, Amlodipine / Norvasc]
☑ Diuretic [ex: Amiloride / Midamor, Bumetanide / Bumex, Chlorothiazide / Diuril, Chlorthalidone / Hygroton, Furosemide / Lasix, Hydrochlorothiazide / HCTZ]
☑ Niacin [ex: Niaspan]
☑ Statins [ex: Simvastatin/Zocor, Atorvastatin / Lipitor, Pravastatin / Pravachol, Lovastatin / Mevacor, Ezetimibe + Simvastatin / Vytorin]
☑ Vitamin E
☑ I am not taking any medications.
☑ I am not taking any vitamins.

Patient's Name (print)       Signature       Date       Time

Staff Name / Title           Signature       Date       Time

FOR OFFICE USE ONLY:

Waist: ______ inches        Meds:__________________________ TRG ______ mg / dL
Hip: ______ inches           TC ______ mg / dL
Left BP: ______ / ______ mmHg  GLU ______ mg / dL
Right BP: ______ / ______ mmHg HDL ______ mg / dL
HR: ______                  LDL ______ mg / dL
                             VLD ______ mg / dL
                             TC/HDL ______