

Name: _____ Date: _____ Date of Birth: _____
 Physician who ordered test: _____ Other Physicians: _____

RISK FACTORS

Do you have heart disease? Yes ___ No ___ If **YES**, please check the appropriate items.
 Heart attack ___ Heart failure ___ Coronary bypass ___ Valve problems ___ Heart artery block ___
 If you have a stent is it bare metal or drug eluding _____
 If you have had bypass surgery, is your graft Saphenous vein or LIMA/RIMA _____

Are you diabetic? Yes: ___ No: ___ If **YES**, are taking insulin? Yes: ___ No: ___

Have you ever smoked? Yes: ___ No: ___ If **YES**, please answer the following questions.
 Total number of years ___ Pack per day ___ Are you smoking now? ___ If not, years since quitting ___

Have you had disease in arteries other than the heart? Yes ___ No ___

Height _____ Weight _____

Have your blood relatives had heart attacks or heart artery blockages? Yes ___ No ___ Don't know ___
 If **YES**, please check the appropriate items.

	Under age 55	55-64	65 and up		Under age 55	55-64	65 and up
Brother				Maternal grandfather			
Sister				Maternal grandmother			
Father				Maternal uncle			
Mother				Maternal aunt			
Son				Paternal grandfather			
Daughter				Paternal grandmother			
Other				Paternal uncle			
				Paternal aunt			

If Female: Dress size ___ Do you still have periods? ___ I
 If **NO**, what age did they stop? ___ Have your ovaries been removed? ___ If **YES**, at what age? ___
 Are you on hormone replacement? ___ If **YES**, age started: ___ age stopped ___

MEDICATIONS: Blood Pressure medication: Yes ___ No ___
 Daily Aspirin: Yes ___ No ___ If yes what strength
 Are you on cholesterol or lipid lowering medication? Yes ___ No ___. If **YES**, how long have you been on this medication? _____ What physician probably knows your original cholesterol values before you started taking medication: _____

Are you taking Viagra, Levitra or Cialis? Yes ___ No ___
 Please list all other medications that you are taking. Include dose, mg and the number of times per day

Please list surgeries and other conditions:

Contrast/Beta Blocker contraindications:
 Allergies: None ___ Hayfever ___ Shellfish ___ Penicillin ___ Demerol ___ Iodine ___ Asthma ___ Sulfa ___
 X-ray contrast/dye ___ Other _____
 Previous Contrast Injection ___ Kidney Problems ___ Liver Problems ___ Multiple Myeloma ___
 On Chemotherapy ___ Congestive Heart Failure ___ Irregular Heart Rhythm ___

Have you had a stress test, cardiac cath or cholesterol test in the last 12 months? If **YES** please give location and date: _____