

CARDIAC CTA MEDICAL HISTORY FORM

Name Last _____ First _____ M.I. _____
 Date of Birth ____ / ____ / ____ Age ____ RA # _____
 Height _____ Weight _____ Sex M F

Please mark the appropriate answers:

	<u>Yes</u>	<u>No</u>		
<u>Your Risk Factors</u>				
Current Smoker	___	___	If so, how many years?	_____
Former Smoker	___	___	If so, how many years?	_____
Diabetes	___	___	If so, do you take insulin?	_____
High Blood Pressure	___	___	If so, how high?	_____
Overweight	___	___		
Heart Disease in Family	___	___	If so, who?	_____
High Cholesterol	___	___	If so, how high?	_____
High Triglycerides	___	___	If so, how high?	_____

<u>Your Symptoms</u>				
Chest Pain or Pressure	___	___	If so, what details?	_____
Upper Back Pain	___	___	If so, what details?	_____
Shortness of Breath	___	___	If so, what details?	_____

<u>Your Heart History</u>				
Coronary Artery Disease	___	___	If so, what details?	_____
Heart Attack	___	___	If so, what details?	_____
Heart Valve Disease	___	___	If so, what details?	_____
Heart Arrhythmia	___	___	If so, what details?	_____
Congestive Heart Failure	___	___	If so, what details?	_____
Other Heart or Lung Disease	___	___	If so, what details?	_____

<u>Prior Heart Tests</u>				
Treadmill Stress Test	___	___	If so, what details?	_____
Nuclear Stress Scan	___	___	If so, what details?	_____
Echocardiogram	___	___	If so, what details?	_____

<u>Prior Heart Procedures</u>				
Coronary Angioplasty	___	___	If so, what details?	_____
Coronary Stent Placement	___	___	If so, what details?	_____
Bypass Surgery (CABG)	___	___	If so, what details?	_____
Other Heart Surgery	___	___	If so, what details?	_____
Pacemaker or Defibrillator	___	___	If so, what details?	_____

Current Heart Medications _____

Signature _____ Date _____

