

Patient History

Patient Name: _____ DOB: _____ Age: _____

Identification: African-American Asian Caucasian Hispanic Native-American Other: _____

Reason for requesting scan: _____

Allergies: _____ Current Medications: _____

Risk Factors:

Smoking history: Packs Per Day _____ # yrs _____ # yrs since quitting _____
Second Hand Exposure: _____ # yrs _____

How much do you exercise? Hours per Day _____ Hours per Week _____ Type? _____

How much fatty foods are in your diet?
High _____ Moderate _____ Low _____

If you consider yourself overweight, by how much?

By 5 – 10 pounds _____ By 25 – 50 pounds _____
By 10 – 25 pounds _____ By more than 50 pounds _____

What is your waist measurement? _____ Inches

How would you rate the stress in your daily life?

High _____ Moderate _____ Low _____ None _____

Years since menopause? _____ yrs NA _____

Have YOU had any of the following symptoms recently?

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Heartburn/Acid Reflux |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Leg cramping | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Urination problems |
| <input type="checkbox"/> Weakness/ Fatigue | <input type="checkbox"/> Left arm pain | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Dizziness/Lightheaded | <input type="checkbox"/> Upper/Low Back pain | <input type="checkbox"/> Surgeries _____ |

Do YOU have a history of any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney stones/infection |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma/Hay fever | <input type="checkbox"/> "Mini-Stroke" (TIA) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Asbestos/toxic fumes |

Have you ever had cancer? Yes No If yes, type? _____ Date: _____

Have you ever had a stress test, placement of a stent, angioplasty or heart surgery? Yes No

If yes, when? _____ Do you know which vessels had stent placement? _____
Results? _____

Have you ever had a CT scan ("CAT Scan")? Yes No

If yes, when and what were the results? _____

Do you have a FAMILY history of:

Heart Disease? Yes No If yes, who? _____

Stroke? Yes No If yes, who? _____

Cancer? Yes No If yes, who? _____

Is there any other information, which you feel would be pertinent, or which better describes your reason for taking this test? _____