



## Cardiac CT Questionnaire

Please indicate your age, height and weight:

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Cardiac Risk Factors:** Please indicate if you have a history of, or see a doctor, or have previously been told that you have any of the following problems.

	YES	NO	DON'T KNOW
High Blood Pressure (Hypertension) (even if blood pressure is currently controlled with medications)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol (even if Cholesterol is currently controlled with medications)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take Insulin for Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many years?	_____		
Smoke cigarettes currently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many years?	_____		
Previously smoked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When did you quit?	_____		
Congratulations. How many years did you smoke?	_____		
Does your immediate family have a history of Coronary artery disease (heart attack or angioplasty or coronary bypass surgery in a first degree relative - your brother, sister, mother, or father)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At what age did your first degree relative(s) have the heart attack or angioplasty or bypass surgery?	_____		

## Cardiac CT Questionnaire

### **Other Medical History:**

Please indicate if you have or have had any of the following diagnoses.

	YES	NO	DON'T KNOW
Do you have known, diagnosed Coronary Artery Disease (Coronary Heart Disease, or Coronary Atherosclerosis)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Congestive Heart Failure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Valvular Heart Disease (or Heart Valve Disease such as regurgitation or leaky valve or stenotic valve)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to IV Contrast or IV Dye or X-Ray Dye or Iodine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do have Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a chance that you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you taken an ED drug in the past 24 hours (Levitra or Cialis or Viagra)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Cardiac CT Questionnaire

**Current Clinical History:**

What is the reason you are having this scan done today?

\_\_\_\_\_ Screening for Coronary Artery Disease because of High Risk Factors?

\_\_\_\_\_ Symptoms concerning heart trouble?

Please take a few words to describe your symptoms:

\_\_\_\_\_ Abnormal Stress Test result

\_\_\_\_\_ Per Doctor's instructions (not exactly sure of reason)

**Prior Testing:** Please indicate if you have had any of the following procedures. If you have, please indicate when (the most recent if multiple times) and where (name of hospital or clinic).

	Procedure	When?	Where?
<input type="checkbox"/>	Stress Test		
<input type="checkbox"/>	Heart Scan or Calcium Scan or Calcium Score		
<input type="checkbox"/>	Cardiac Cath		
<input type="checkbox"/>	Heart Artery Angioplasty or balloon Dilation or Stent		
<input type="checkbox"/>	Heart Bypass Surgery		
<input type="checkbox"/>	Heart Valve Surgery		
<input type="checkbox"/>	Pacemaker or Defibrillator		
<input type="checkbox"/>	Echocardiogram		
<input type="checkbox"/>	Cardiac MRI		

**Lastly, medications:** Please list your current medications here:

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