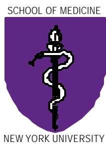

RADIOLOGY

HEART / CARDIAC QUESTIONNAIRE

NAME: ____ **AGE:** __________ **SEX:** o M o F

DIAGNOSIS (Why are you having this study?): ____

____

PLEASE CHECK EACH BOX THAT APPLIES TO YOU (AND ANSWER QUESTIONS):

- o Chest pain
- o Shortness of breath
- o Fatigue
- o Lightheadedness
- o Stroke/TIA
- o Angina
- o Coronary artery disease
- o Congestive heart failure
- o High blood pressure (hypertension) (What is your blood pressure?) ______________________

  How long have you had hypertension? ____________________________________

  Are you taking blood pressure medications? o Yes o No

  If yes, list your medications: ____

  ____
- o Smoking

  How many packs per day? ______________

  How many years have you smoked? _______________
- o Diabetes
- o Coronary angioplasty? (If so, please describe.) ____________________________________

  ____
- o Heart surgery? (If so, please describe.) ____

  ____
- o Vascular surgery? (If so, please describe.) ____

  ____
- o Other medical conditions?

  ____

PRIOR STUDIES AND INTERVENTION:

- o Prior MRI (when?) ________________________ (where?) _________________________________
- o Angiogram (when?) ________________________ (where?) _________________________________
- o Echocardiogram (when?) _________________ (where?) _________________________________
- o CT (CAT) scan (when?) __________________ (where?) _________________________________
- o Nuclear medicine scan (when?) ____________ (where?) _________________________________

- Stress test (when?) ______________________ (where?) ________________________________