

MIDWEST CARDIOLOGY ASSOCIATES, P.C.

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Patient Name: _____	Date: _____
Height: _____ Weight: _____	DOB: _____

PLEASE CHECK THE FOLLOWING:

History of Prior MI (heart attack)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____
History of Angiography	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____
History of Stenting and/or Angioplasty Balloon	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____
History of Cardiac Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____
Bypass _____ Heart Transplant _____	Aortic Valve _____ Mitral Valve _____		
History of lung disease (COPD, Asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____
Do you use inhalers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	____/____/____

RISK FACTORS:

Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Family History of CAD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Quit? _____ months/ yrs ago	

SYMPTOMS:

History of chest pain within last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does it occur during physical exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does it go away with rest or nitroglycerin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experience shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Admitted for chest pain (or equivalent)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Why did your doctor order this exam?	_____

OTHER:

Have you walked on a treadmill before? Yes No
 Do you regularly exercise? Yes No
 Please list your current medications: _____

Please list any medications you are allergic to: _____
 Have you taken the medication theophylline in the last 24 hours? Yes No

Female patients please fill out back of questionnaire

Referring Physician: _____ Primary Physician: _____

Staff Use Only:

1. Heart sounds: _____
2. Lung sounds: _____
3. Orthopedic problems: _____
4. Good verbal feedback regarding instructions? Yes No
5. Permit signed? Yes No (test canceled)

Signature: _____

MIDWEST CARDIOLOGY ASSOCIATES QUESTIONNAIRE FOR FEMALE PATIENTS

To be completed by all female patients.

A nuclear scan is potentially harmful to an unborn fetus, consequently we must know if you are pregnant or could be pregnant prior to proceeding with your exam. Please answer the following questions.

Patient's Name: _____

Patient's ID No.: _____

1. Are you (check the appropriate box):

Post-menopausal

Pre-menopausal, surgically sterile (e.g. hysterectomy, tubal ligation, etc.)

Pre-menopausal, not surgically sterile. If so, are you or do you think you may be pregnant? Yes No

The date of your last menstrual period was: _____

2. Are you currently breast-feeding?

3. Have you ever had a mastectomy? Yes No

Right

Left

Implant

Prosthesis

I consent to have a Nuclear Cardiology Test.

Patient's Signature: _____

Date: _____