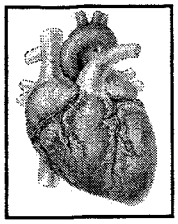

ICMG

Interventional Cardiology Medical Group

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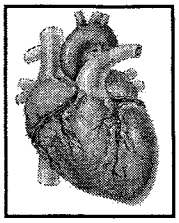

Patient Name: Last _____ First _____ Date: _____

Sex: ❑ Male ❑ Female Date of Birth: _____ Height: _____ ft. _____ in. Weight: _____ lb.

Referring M.D.: _____ Diagnosis: _____

_____

Please answer the following questions. You may circle YES or NO or fill in the blanks.

NO YES 1- Have you ever had a stress test? If YES, When? _____ ❑ +ve ❑ -ve

NO YES 2- Have you ever had a heart attack? If YES, When? _____

NO YES 3- Have you ever had an angiogram or angioplasty? If YES, When? _____

NO YES 4- Have you ever had a heart surgery? If YES, When? _____

NO YES 5- Have you ever had a heart bypass surgery? If YES, When? _____

NO YES 6- Have you ever had a breast surgery? If YES, Do you have an implant? ❑ YES ❑ NO

NO YES 7- Have you ever smoked? If YES, How many years and how much? _____

NO YES 8- Have you experienced any chest pain recently? If YES, When? _____

How long did it last? _____

Where in your chest did you feel the pain? ❑ Center ❑ Right ❑ Left

Was the pain related to exercise or stress? ❑ YES ❑ NO

NO YES 9- Have you ever taken nitroglycerine for chest pain?

NO YES 10- Are there any family members with heart disease? If YES, Who? _____

NO YES 11- Have you ever been told by a physician that you have high blood pressure?

If YES, What medication(s) do you take? _____

NO YES 12- Have you ever been told by a physician that you have diabetes?

If YES, What medication(s) do you take? _____

NO YES 13- Have you ever been told by a physician that you have high cholesterol?

If YES, What medication(s) do you take? _____

NO YES 14- Have you ever been told by a physician that you have ❑ asthma, ❑ emphysema or ❑COPD? If YES, What medication(s) do you take? _____

NO YES 15- Are you allergic to any food or medication? If YES, What? _____

NO YES 16- Have you had any other imaging procedure during the last three days? If YES, What?

NO YES 17- Can you walk fast and non-stop for six minutes or more? If NO, Why? _____

18- Other than mentioned above, What medications are you currently taking? _____

_____

Patient Signature _____