ICMG
Interventional Cardiology Medical Group

23101 Sherman Place, Suite # 110, West Hills, CA 91307
Tel: (818) 702-8800 Fax: (818) 702-0080

Patient Name: Last _____ First _____ Date:_____

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

Referring M.D.:_____ Diagnosis:_____

Please place a check mark in the box next to the statement that BEST describes the reason you are undergoing cardiac stress testing today.

☐ I have had a heart attack (myocardial infarction or MI) Month/Year: _____ (410.xx)

☐ I have had heart bypass surgery Month/Year:_____ (V45.81)

☐ I have had an angiogram or angioplasty/stent in a heart artery (414.01)

☐ I have a blockage in the blood supply to my heart (414.01)

☐ I have been diagnosed with congestive heart failure (CHF) (428._ _)

☐ I have a weak heart muscle and/or poor heart function (425.4)

☐ I need my heart checked before I have surgery (V72.81)

I have been experiencing the following symptoms: (check all that apply)

☐ pain or discomfort in or around my chest (786.59)
☐ shortness of breath and/or trouble breathing (786.05)
☐ premature beats and/or an irregular heart rhythm (427.69)

Do the symptoms occur with exercise or activity? ☐ Yes ☐ No With rest? ☐ Yes ☐ No
How frequently do the symptoms occur?_____
When did you last experience the symptoms? _____

Please answer the following questions.

☐ Yes ☐ No Do you have a history of smoking? # years_____ #packs/day_____
☐ Yes ☐ No Have you been told you have high blood pressure?
☐ Yes ☐ No Have you been told you have diabetes?
☐ Yes ☐ No Have you been told you have high cholesterol?
☐ Yes ☐ No Do you have family members with heart disease? Whom?_____
☐ Yes ☐ No Do you have breast implants?
☐ Yes ☐ No Do you have asthma ☐ emphysema ☐ COPD ☐
☐ Yes ☐ No Have you had an imaging procedure during the last three days? Proc._____
☐ Yes ☐ No Do you have allergies to food or medication?
If yes, list allergies:_____