HEART SCREEN/CALCIUM SCORING

Life. Well seen.

Patient name: ______________________________ Date: ____________________

Referring Provider: __________________________ Date of Birth: ______________

Type of Exam: HEART SCREEN/CALCIUM SCORING Weight: ____________________

Do you have any chest complaints and/or problems at this time? ☐ YES (please explain) ☐ NO

____

____

How long have you had these symptoms? ____________________________________

How severe are these symptoms? ☐ NONE ☐ MILD ☐ MODERATE ☐ SEVERE

Have you had caffeine in the last 4 hour? ☐ YES ☐ NO

Have you had other Heart Screens or CT of the Chest? ☐ YES ☐ NO

If yes, FACILITY NAME: ______________________________ DATE: ____________

Family History of Heart Disease: ☐ YES ☐ NO IF YES, Who? ______________________

Do you have or have you had in the past any of the following medical problems?

High Cholesterol: ☐ Yes ☐ NO

High blood pressure: ☐ Yes ☐ NO

Heart Attack: ☐ Yes ☐ NO

Stroke: ☐ Yes ☐ NO

Diabetes: ☐ Yes ☐ NO

Surgery to Chest, Heart, or Lungs: ☐ Yes ☐ No

If yes, explain ____

Thyroid Problems: ☐ Parathyroid ☐ Hypothyroidism ☐ Hyperthyroidism ☐ None

Cancer, where? ____

Are you a current smoker: ☐ Yes ☐ NO If Yes, How long have you smoked? __________

Are you a former smoker: ☐ Yes ☐ NO If Yes, How long did you smoke? __________

If Yes, How long since you quit? __________

Are you now or is there a possibility that you are pregnant? ☐ YES ☐ NO ☐ N/A