NUCLEAR CARDIOLOGY PATIENT QUESTIONNAIRE

Name: _____ Test Date: _____

Have you ever had a heart attack? ( ) Yes ( ) No
if yes, month and year _____

Have you ever had a coronary angioplasty ***or*** coronary stent? ( ) Yes ( ) No
if yes, month and year _____

Have you had coronary bypass surgery? ( ) Yes ( ) No
if yes, month and year _____

Do you have: Hypertension (high blood pressure) ( ) Yes ( ) No
Diabetes ( ) Yes ( ) No
High Cholesterol ( ) Yes ( ) No
Active Smoking ( ) Yes ( ) No
Family History of heart disease (before age 60) ( ) Yes ( ) No
Pacemaker ( ) Yes ( ) No
Asthma ( ) Yes ( ) No

Symptoms:

Do you experience these symptoms: Shortness of breath ( ) Yes ( ) No
Chest pain/pressure ( ) Yes ( ) No
Other pain or pressure? (circle all that apply) [jaw, neck, throat, arm, back) ( ) Yes ( ) No

Do your symptoms occur with exertion? ( ) Yes ( ) No
Do your symptoms occur at rest? ( ) Yes ( ) No
Are your symptoms relieved with nitroglycerin? ( ) Yes ( ) No
Are your symptoms relieved with rest? ( ) Yes ( ) No

Have you had caffeine within the past 24 hours? ( ) Yes ( ) No
If yes, please indicate what and how many hours ago _____

What medication(s) do you currently take?

Medication	Dose	Last Taken