Patient Name: (last) _____ (first) _____ Date: _____

Sex: ☐ Male ☐ Female Date of Birth: _____Height: _____ Weight: _____

Referring MD: _____ 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 been told that I had a heart attack (myocardial infarction or MI) Month/Year: _____ (I21.xx)
- ☐ I had heart surgery bypass surgery Month/Year: _____ (Z95.1)
- ☐ I have had an angiogram or angioplasty/stent in a heart artery (I25.10)
- ☐ I have had a blockage in the blood supply to my heart (I25.10)
- ☐ I have been diagnosed with congestive heart failure (CHF) (I50.9)
- ☐ I have a weak heart muscle and/or poor heart function (I42.5)
- ☐ I need my heart checked before I have surgery (Z01.810)

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

- ☐ Pain or discomfort in or around my chest (R07.82)
- ☐ Shortness of breath and/or trouble breathing (R06.02)
- ☐ Premature beats and/or an irregular heart rhythm (I49.3)

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 symptom(s)? _____

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 _____

_____