Nuclear Cardiology Questionnaire

Date ______________________

Print Name ____

Allergies ____

1. Age _____ 2. Sex ( ) Male ( ) Female 3. Weight in Pounds _____
4. Height _______ 5. DOB _______
6. Coffee, tea, or chocolate this morning? ____
7. When was the last time you ate?____

Symptoms

8. Chest pain?...( ) Yes ( ) No

   How long? ____

   Does the pain involve arm or neck?...( ) Yes ( ) No

   Last time you had chest pain? ____

9. Shortness of breath?...( ) Yes ( ) No
10. Nausea/Vomiting?...( ) Yes ( ) No

Medical History

11. Heart attack in the past?..( ) Yes ( ) No
12. Heart Surgery? ....( ) Yes ( ) No
13. Heart Catheterization? ....( ) Yes ( ) No

    Angioplasty? ....( ) Yes ( ) No

14. High blood pressure? ....( ) Yes ( ) No
15. Diabetes?..( ) Yes ( ) No
16. High cholesterol? ....( ) Yes ( ) No
17. Smoke?...( ) Yes ( ) No
18. Asthma? ....( ) Yes ( ) No
19. Emphysema?...( ) Yes ( ) No
20. Family history of heart disease? ....( ) Yes ( ) No
21. Previous stress test? ....( ) Yes ( ) No

    When? ____

    Can you walk fast for 5 minutes or more?.....................................( ) Yes ( ) No

22. Do you have glaucoma?...( ) Yes ( ) No
23. List the medication(s) you are taking .

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