Patient Label

CARDIAC DIAGNOSTICS
PATIENT QUESTIONNAIRE

In order to assist us in performing and interpreting your cardiac test results, please take a few moments to complete this questionnaire. All information will be treated with confidentiality and will be used solely for medical purposes.

Name: _____ Age: _____

Height: _____ Weight: _____ (actual / approximate -please circle)

Please circle all symptoms that you have:

CHEST PAIN
SHORTNESS OF BREATH
PALPITATIONS
LIGHTHEADEDNESS
FAINTING
SWELLING OF THE ANKLES
OTHER: (please specify) _____

Please list all MEDICATIONS that you are taking (prescription and non-prescription)

_____

_____

_____

_____

Please indicate YES or NO to the following:

High Blood Pressure	YES	NO	IF YES, HOW LONG _____
Diabetes	YES	NO	IF YES, HOW LONG _____
High Cholesterol	YES	NO	IF YES, HOW LONG _____
Angina	YES	NO	IF YES, HOW LONG _____
Emphysema	YES	NO	IF YES, HOW LONG _____
Cancer	YES	NO	IF YES, HOW LONG _____ TYPE _____
Previous heart attack	YES	NO	IF YES, HOW LONG AGO _____
Previous stroke	YES	NO	IF YES, HOW LONG AGO _____
Previous heart surgery or angioplasty	YES	NO	IF YES, HOW LONG AGO _____
Previous pacemaker	YES	NO	IF YES, HOW LONG AGO _____
Previous heart rhythm problem	YES	NO	IF YES, HOW LONG AGO _____
Smoking	YES	NO	How much daily? _____ packs/day, _____ years Quit?—What year._____
Family history of heart disease	YES	NO	IF YES, specify who and age: _____ _____

Technologist: _____ Date: _____