LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

CARDIAC SCORING SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Weight? Height?

Are you a smoker? ☐YES ☐NO If you quit, how long ago:

Family history of CAD (coronary artery disease)? ☐YES ☐NO If YES, what age:

History of heart attack? ☐YES ☐NO If YES, what age:

Family history of heart attack? ☐YES ☐NO If YES, what age:

Do you exercise daily? ☐YES ☐NO Frequency of exercise (per week):

History of blood pressure? ☐YES ☐NO
If you are not on medication, is your blood pressure normally over 140/90? ☐YES ☐NO ☐UNKNOWN

History of high cholesterol? ☐YES ☐NO Is it greater than 200?: ☐YES ☐NO ☐UNKNOWN

History of diabetes? ☐YES ☐NO

Are you taking any medicine for high cholesterol, blood pressure or diabetes? ☐YES ☐NO

SCREENED BY: SCREENED WITH:

Technologist comments:

Technologists initials:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /