

PARK WEST RADIOLOGY

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: / /