### CARDIAC IMAGING QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Demographics: What is your ethnicity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ African American</td>
</tr>
<tr>
<td>☐ Asian/Pacific Islander</td>
</tr>
</tbody>
</table>

The following body measurements help in the interpretation of your test results

| Height: __________ inches | Weight: __________ pounds |

## Medical History

1. Have you had any **caffeine-containing** beverages, foods or medicines (including soda, energy drinks, coffee, decaffeinated coffee, tea, chocolate, cocoa, Excedrin, etc.) within the past 24 hours?
   - ☐ No  ☐ Yes—please specify products: __________________________

2. Have you ever been told you have **asthma** or another chronic respiratory disease?
   - ☐ No  ☐ Yes—please specify name(s) of condition: __________________________

3. Is this test being done as part of a **pre-op** evaluation for surgery?
   - ☐ No  ☐ Yes—please specify type of surgery: __________________________

4. Are you allergic to **iodine contrast**?
   - ☐ No  ☐ Yes

## Symptoms

**Important:** If you have had bypass surgery, angioplasty or a heart attack in the last 12 months, describe any discomfort since then.

1. **Chest Pain/Discomfort:**
   - Have you had pain or discomfort above your waist in the last 12 months
     - ☐ No  ☐ Yes—If “Yes”:
       a. Approximately how long have you had this pain or discomfort? __________________________
       b. Does the pain/discomfort occur mostly in the center of your chest?  ☐ No ☐ Yes
          If not, which of the following locations describe most of your discomfort?
          - ☐ Left side of the chest  ☐ Left arm  ☐ Neck or jaw  ☐ Other, specify: __________________________
       c. Does the pain/discomfort occur commonly with physical exertion?  ☐ No ☐ Yes
          If “yes,” does the pain/discomfort most often go away within 10 minutes with rest?  ☐ No ☐ Yes
       d. Does the pain/discomfort go away with nitroglycerin?  ☐ Never taken  ☐ No ☐ Yes
       e. Has this pain or discomfort been getting worse during the last month
          (i.e., more often, more severe or intense, or lasting longer)?  ☐ No ☐ Yes
### Symptoms (continued)

2. **Shortness of Breath:**
   a. Have you had unusual shortness of breath in the last 12 months? [ ] No [ ] Yes
   b. Do you have shortness of breath during physical exertion? [ ] No [ ] Yes
   c. Have you had worsening shortness of breath during the last month (i.e., more often, more severe or intense, or lasting longer)? [ ] No [ ] Yes

3. **Other Symptoms:**
   Have you had any of the following in the last 12 months?
   - Palpitations [ ] No [ ] Yes
   - Fainting, syncope (blackouts) [ ] No [ ] Yes

### Cardiac History

1. Have you ever had the following:
   a. Heart attack (myocardial infarction)? [ ] No [ ] Yes
      - Date of most recent (MM-DD-YY): __________ - __________ - __________
      - Location (Hospital, City, State): __________________________
   b. Cardiac catheterization for a coronary angiogram? [ ] No [ ] Yes
      - Date of most recent (MM-DD-YY): __________ - __________ - __________
      - Location (Hospital, City, State): __________________________
   c. Coronary angioplasty (balloon or stent)? [ ] No [ ] Yes
      - Date of most recent (MM-DD-YY): __________ - __________ - __________
      - Location (Hospital, City, State): __________________________
   d. Congenital heart disease (problems with your heart chamber/valves, “holes” or “murmur” in the heart)? [ ] No [ ] Yes
      - Describe type of congenital heart disease: __________________________
   e. Heart surgery?
      - Date of most recent (MM-DD-YY): __________ - __________ - __________
      - Location (Hospital, City, State): __________________________
      - What type of heart surgery did you have? Mark all that apply.
        - [ ] Bypass surgery
        - [ ] Valve surgery
        - [ ] Heart transplant
        - [ ] Other: __________________________
        - [ ] Congenital (describe repair): __________________________
   f. Pacemaker? [ ] No [ ] Yes
   g. Defibrillator (ICD)? [ ] No [ ] Yes
## Cardiac History (continued)

2. Have you ever been told by a healthcare practitioner that you have:
   a. High blood pressure (hypertension)  
   b. High cholesterol
   c. Diabetes
   d. A heart valve problem
   e. Cardiomyopathy
   f. Atrial flutter or fibrillation
   g. Heart failure
   h. Stroke or TIA (transient ischemic attack)
   i. Renal (kidney) failure of dysfunction
   j. Autoimmune disease
   k. Sleep apnea
   l. Chronic obstructive pulmonary disease (COPD)
   m. Cancer

   a. No  
   b. Yes

3. Do you experience a cramping pain in your calves when you walk, which your doctor has called **peripheral arterial disease** or claudication?
   a. No  
   b. Yes

4. Do you currently or have you **ever** smoked cigarettes?
   a. No  
   b. Yes—If “Yes”:
      a. How many years did you smoke? 
      b. How many packs per day on average?  
      c. Have you stopped smoking?  

   a. No  
   b. Less than ½ pack  
   c. ½ to 1 pack  
   d. More than 1 pack

5. Please list any other **serious medical problems**:  
   a. None

6. Females:
   a. Are you postmenopausal?  
   b. If “yes,” are you taking estrogen replacement?
       a. No  
       b. Yes

## Family History of Heart Disease

Do you have any close blood relative(s) who developed coronary heart disease **before age 55 for male relatives or before 65 for female relatives** (e.g., child, parents, siblings, grandparents)?
   a. No  
   b. Yes—specify how many:  
   c. Don’t know
# Cardiac Imaging Questionnaire

## Exercise and Diet

Circle one number only that best answers each question.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. How much do you exercise?</td>
<td>0</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>b. How much does the status of your heart limit your day-to-day physical activities?</td>
<td>0</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>c. How much does the status of your heart limit your emotional wellbeing?</td>
<td>0</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>d. To what extent are you on a low saturated fat diet?</td>
<td>Very high fat</td>
<td>Very low fat</td>
</tr>
</tbody>
</table>

## Medications

Are you taking any of the following medications? Check all that apply.

- **ACE inhibitors** (Captopril/capoten, Quinapril/accupril, Lisinopril/zestril, Ramipril/altace, Benazepril/lotensin, Monopril/fosinopril)
- **ARBs** (Losartan/cozaar, Hyzaar, Avapro/irbesartan, Diovan/valsartan, Telmisartan/micards, Altacand/candesartan, Olmesartan/benicar, Eprosartan/teveten)
- **Aspirin** (Bayer, Ecotrin)
- **Beta blockers** (propranolol, atenolol, timolol, sotalol)
- **Calcium channel blockers** (Novasc/amlodipine, Cardizem, Tiazac/diltiazem, felodipine, verapamili)
- **Cholesterol drugs** (ezetimibe, PCSK9 inhibitors [Repatha, Praluent], statins [Lipitor/atorvastatin, Crestor/rosuvastatin], Vascepa)
- **Diuretic** (Midamor/amiloride, Bumex/bumetanide, Diuril/chlorothiazide)
- **Hormone replacement therapy**
- **Niacin**
- **Nitrates** (i.e., nitroglycerin, nitrolingual)
- **Oral diabetic medications or insulin**
- **Other chest pain medications** (blood thinner, thrombolytic drug [Eminase/anistreplase, Retavase/reteplase])
- **Other platelet inhibitors** (i.e., Plavix/clopipodogrel, Aggrenox/dipyridamole, Brilinta)
- **Other blood pressure lowering drug** (Cardura, Minipress, Hytrin, methyldopa, carvedilol, Hycor, Ismelin, Loniten)
- **I am not taking any of these medications.**

<table>
<thead>
<tr>
<th>Patient name (please print)</th>
<th>Patient signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff name/Title (please print)</td>
<td>Staff signature</td>
<td>Date</td>
<td>Time</td>
</tr>
</tbody>
</table>

## For office use only:

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waist</td>
<td>inches</td>
</tr>
<tr>
<td>Hip</td>
<td>inches</td>
</tr>
<tr>
<td>Left BP</td>
<td>mmHg</td>
</tr>
<tr>
<td>Right BP</td>
<td>mmHg</td>
</tr>
<tr>
<td>HR</td>
<td></td>
</tr>
<tr>
<td>TRG</td>
<td>md/dL</td>
</tr>
<tr>
<td>TC</td>
<td>md/dL</td>
</tr>
<tr>
<td>GLU</td>
<td>md/dL</td>
</tr>
<tr>
<td>HDL</td>
<td>md/dL</td>
</tr>
<tr>
<td>LDL</td>
<td>md/dL</td>
</tr>
<tr>
<td>VLD</td>
<td>md/dL</td>
</tr>
<tr>
<td>TC/HDL</td>
<td></td>
</tr>
</tbody>
</table>