Cedars Sinai
S. Mark Taper Foundation
Imaging Center

CARDIAC IMAGING QUESTIONNAIRE

PATIENT I.D.

Patient Information

Age: _____ Sex (assigned at birth): ❑ Male ❑ Female ❑ Intersex ❑ Choose not to disclose

Demographics: What is your ethnicity?

❑ African American ❑ Caucasian ❑ Native American
❑ Asian/Pacific Islander ❑ Hispanic/Latino ❑ Other (specify): _____

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

Height: _____ feet _____ 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® [acetaminophen/aspirin/caffeine], etc.) within the past 24 hours?

   ❑ No ❑ Yes—please specify products: _____

2. Have you ever been told you have asthma or other chronic respiratory disease?

   ❑ No ❑ Yes—please specify name(s) of condition(s): _____

3. Are you allergic to iodine contrast? ❑ No ❑ Yes

Symptoms

1. Chest pain/discomfort
   Have you had worsening chest pain/discomfort during the last 12 months (i.e., more often, more severe or intense, or lasting longer)? ❑ 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? ❑ Yes ❑ No
      If "No," 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

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Symptoms *(continued)*

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

2. Shortness of breath
   a. Do you have shortness of breath during physical exertion? ❑ No ❑ Yes
   b. 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. Do you experience a cramping pain in your calves when you walk? ❑ No ❑ Yes

Cardiac History

1. Have you ever had the following (check all that apply):
   - ❑ Heart attack (myocardial infarction) Date (MM/DD/YYYY): _____
   - ❑ Defibrillator/ICD Date (MM/DD/YYYY): _____
   - ❑ Coronary stent placement Date (MM/DD/YYYY): _____
   - ❑ Heart transplant Date (MM/DD/YYYY): _____
   - ❑ Valve replacement Date (MM/DD/YYYY): _____ Specify type: _____
   - ❑ Bypass surgery Date (MM/DD/YYYY): _____

2. Have you ever been told by a healthcare practitioner that you have:
   a. High blood pressure (hypertension) ❑ No ❑ Yes
   b. High cholesterol ❑ No ❑ Yes
   c. Diabetes ❑ No ❑ Yes
   d. A heart valve problem ❑ No ❑ Yes
   e. Cardiomyopathy/heart failure ❑ No ❑ Yes
   f. Atrial fibrillation (AFib) ❑ No ❑ Yes
   g. Stroke/transient ischemic attack (TIA) ❑ No ❑ Yes
   h. Renal (kidney) failure or dysfunction ❑ No ❑ Yes
   i. Autoimmune disease (i.e., lupus, psoriasis) ❑ No ❑ Yes
   j. Sleep apnea ❑ No ❑ Yes

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Cardiac History *(continued)*

k. Chronic obstructive pulmonary disease (COPD) ..... ❑ No ❑ Yes

l. Cancer ..... ❑ No ❑ Yes

m. Peripheral artery disease (PAD) ..... ❑ No ❑ Yes

3. Do you currently smoke cigarettes or have you smokes cigarettes? ❑ No ❑ Yes

   If "Yes," how many years did you smoke? _____ How many packs per day on average: _____

4. Have you stopped smoking cigarettes? ❑ No ❑ Yes

   If "Yes," please specify the date: _____

Family History of Heart Disease

Do you have any close blood relatives who developed coronary heart disease before age **55 for male relatives or before 65 for female relatives** (child, parents, siblings)? ❑ No ❑ Yes ❑ Don't know

Diet

Rate yourself. Circle one number only that best answers each question:

1. To what extent are you on a low saturated fat diet (low in animal fat)?

   Very high fat — Very low fat

   0 1 2 3 4 5 6 7 8 9 10

2. To what extent do you consume sugary food/drinks?

   Never — Always

   0 1 2 3 4 5 6 7 8 9 10

3. To what extent do you eat five or more fruit/vegetable servings in a day?

   Never — Always

   0 1 2 3 4 5 6 7 8 9 10

Exercise

1. On average, how many days per week do you engage in moderate to strenuous physical exercise per week (write zero if you do not exercise)? _____ days/week

2. If exercising at a moderate to strenuous level, on average, how many minutes do you engage in exercise at that level? _____ minutes/day

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Exercise *(continued)*

3. How many days a week do you perform muscle-strengthening exercise, such as body weight exercise or resistance training? _____ days/week
4. For health reasons, do you have difficulty walking five to six blocks? ☐ No ☐ Yes
5. Do you have difficulty climbing one flight of stairs? ☐ No ☐ Yes

Medications

- ☐ Blood pressure medications
- ☐ Cholesterol drugs
- ☐ Oral diabetic medications
- ☐ Aspirin
- ☐ Diuretic
- ☐ Insulin
- ☐ Tadalafil (Cialis®), Vardenafil (Levitra®), Sildenafil (Viagra®)
- ☐ HIV medication
- ☐ Blood thinners
- ☐ I am not taking any of these medications

Patient name (please print)	Patient signature	Date (MM/DD/YYYY)	Time

Staff name (please print)	Staff signature	Date (MM/DD/YYYY)	Time

For Office Use Only

Waist: _____ inches

Hip: _____ inches

Left BP: _____ / _____ mmHg

Right BP: _____ / _____ mmHg

HR: _____

Meds: _____

_____

_____

_____

_____

_____

_____

_____

TRG _____ md/dL

TC _____ md/dL

GLU _____ md/dL

HDL _____ md/dL

LDL _____ md/dL

VLD _____ md/dL

TC/HDL _____

Creatinine _____