CEDARS-SINAI®
S. MARK TAPER FOUNDATION IMAGING CENTER

CARDIAC IMAGING QUESTIONNAIRE

PATIENT I.D.

Date of test: _____ / _____ / _____
Month day year

_____ _____ _____
Last name First name Middle initial

_____ _____ _____ _____
Street address City State Zip code

Home phone ( ) ____ - _____ Work phone ( ) ____ - _____ Cell Phone ( ) ____ - _____

Email: _____

Age: _____

Sex: ❑ Male ❑ Female

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: ___ inches Weight: ___ pounds Bra size/cup: ___ (eg. 34-B) Breast implants? ❑ Yes ❑ No

(Answer only if you are having a nuclear study)

Emergency contact information:

_____
Last name First name Relationship

Home phone ( ) _____ - _____ Work phone ( ) _____ - _____

Cell phone ( ) _____ - _____ Email: _____

Physician information:

Primary physician: _____ ( ) _____ - _____
Last name First name Fax number *(required for non-Cedars MD)*

Cardiologist: _____ ( ) _____ - _____
Last name First name Fax number *(required for non-Cedars MD)*

Physicians other than listed above to send copy of report:

_____ ( ) _____ - _____
Last name First name Fax number *(required for non-Cedars MD)*

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 other chronic respiratory disease?
   ❑ No ❑ Yes, please specify name of condition: _____

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MEDICAL HISTORY (continued)

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, an angioplasty, or a heart attack in the last 12 months, only describe discomfort since then.

1. **CHEST PAIN / DISCOMFORT:**
   Have you had any 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

2. **SHORTNESS OF BREATH:**
   Have you had any shortness of breath in the last 12 months? ❑ No ❑ Yes
   Do you have shortness of breath during physical exertion? ❑ No ❑ Yes
   Have you had worsening shortness of breath during the last month? ❑ No ❑ Yes
   (i.e. more often, more severe or intense, or lasting longer)

3. **OTHER SYMPTOMS:**
   Have you had any of the following in the last 12 months?
   Palpitations ❑ No ❑ Yes
   Fainting, syncope *(blackouts)* ❑ No ❑ Yes

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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? ❑ No ❑ Yes
      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
   h. Coronary Calcium Scan? *(Coronary calcium score: _____)* ❑ No ❑ Yes
2. Have you ever been told by a health care 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. A heart murmur? ❑ No ❑ Yes
   f. An irregular heartbeat *(arrhythmia)* ❑ No ❑ Yes
   g. Atrial flutter or fibrillation? ❑ No ❑ Yes
   h. Heart failure ❑ No ❑ Yes
   i. Stroke or TIA *(transient ischemic attack)* ❑ No ❑ Yes
   j. Renal *(kidney)* failure or dysfunction ❑ No ❑ Yes
3. Do you experience a cramping pain in your calves when you walk, which your doctor has called **peripheral arterial disease** or claudication? ❑ No ❑ Yes

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4. Do you currently **OR** have you **ever** smoked cigarettes? ❑ No ❑ Yes

   a. How many years did you smoke? _____
   b. How many **packs per day** on average? ❑ Less than ½ pack ❑ ½ to 1 pack ❑ More than 1 pack
   c. Have you stopped smoking? ❑ Yes, specify date stopped: _____ / _____ / _____ ❑ No, did not stop smoking

5. Please list any other SERIOUS MEDICAL PROBLEMS: ❑ None

   _____

   _____

   _____

6. FEMALES:

   Are you POST MENOPAUSAL? ❑ No ❑ Yes

   If YES, are you taking estrogen replacement? ❑ No ❑ Yes

FAMILY HISTORY FOR 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? (i.e. child, parents, siblings, grandparents)

❑ No ❑ Yes, specify how many: _____ ❑ Don't Know

EXERCISE AND DIET

Circle one number only that best answers each question.

a. How much do you exercise? 0 1 2 3 4 5 6 7 8 9 10
   NONE ALWAYS

b. How much does the status of your heart limit your day-to-day physical activities? 0 1 2 3 4 5 6 7 8 9 10
   NONE ALWAYS

c. How much does the status of your heart limit your emotional well-being? 0 1 2 3 4 5 6 7 8 9 10
   NONE ALWAYS

d. To what extent are you on a low saturated fat diet? 0 1 2 3 4 5 6 7 8 9 10
   (0=Very high fat, 10=Very low fat) NONE ALWAYS

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MEDICATIONS

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

- ❑ **Ace Inhibitors** [ex: Catopril / Capoten, Quinapril / Accupril, Lisinopril / Zestril, Ramipril / Altace, Benazepril / Lotensin, Fosinopril / Monopril]
- ❑ **Aspirin** [ex: Bayer, Ecotrin]
- ❑ **Coumadin or Warfarin**
- ❑ **Digoxin** [ex: Digitalis]
- ❑ **Insulin**
- ❑ **Nitrates** [ex: Nitroglycerin, Nitrolingual]
- ❑ **Vitamin C**
- ❑ **Medications for chest pain**
- ❑ **ARBs** [ex: Losartan / Cozaar, Hyzaar, Irbesartan / Avapro, Valsartan / Diovan, Telmisartan / Mycardis, Candesartan / Atacand, Olmesartan / Benicar, Eprosartan / Tevetan]
- ❑ **Blood pressure lowering drugs**
- ❑ **Cholesterol lowering drugs**
- ❑ **Hormone replacement therapy** [Females only]
- ❑ **Oral diabetic medications** [ex: Glucotrol, Actos, Glucophage / Metformin, Glyburide, Actose]
- ❑ **Other platelet inhibitors** [ex: Plavix, Clopidogrel, Aggrenox, Dipyridamole]
- ❑ **Antioxidants**
- ❑ **Beta Blockers** [ex: Acebutolol / Sectral, Atenolol / Tenormin, Betaxolol / Kerlone, Metoprolol / Lopressor, Carvedilol / Coreg, Propranolol / Inderal, Sotalol]
- ❑ **Calcium Channel Blockers** [[ex: Nifedipine/ Procardia, Diltiazem / Cardizem, Verapamil / Calan, Isoptin, Nicardipine / Cardene, Adalate, Felodipine / Plendil, Isradipine / Dynacirc, Amlodipine / Norvasc]
- ❑ **Diuretic** [ex: Amiloride / Midamor, Bumetanide / Bumex, Chlorothiazide / Diuril, Chlorthalidone / Hygroton, Furosemide / Lasix, Hydrochlorothiazide / HCTZ]
- ❑ **Niacin** [ex: Niaspan]
- ❑ **Statins** [ex: Simvastatin/Zocor, Atorvastatin / Lipitor, Pravastatin / Pravachol, Lovastatin / Mevacor, Ezetimibe + Simvastatin / Vytorin]
- ❑ **Vitamin E**
- ❑ **I am not taking any medications.**
- ❑ **I am not taking any vitamins.**

Patient's Name *(print)*	Signature	Date	Time
Staff Name / Title	Signature	Date	Time

FOR OFFICE USE ONLY:

Waist: _____ inches
Hip: _____ inches
Left BP: _____ / _____ mmHg
Right BP: _____ / _____ mmHg
HR: _____

Meds: _____
_____
_____
_____
_____
_____
_____

TRG _____ mg / dL
TC _____ mg / dL
GLU _____ mg / dL
HDL _____ mg / dL
LDL _____ mg / dL
VLD _____ mg / dL
TC/HDL _____