



CALCIUM SCORING QUESTIONNAIRE
Patient Information Form

Name: \_\_\_\_\_

Exam Date: \_\_\_\_\_

Gender: [ ] Male [ ] Female Post Menopausal [ ] Yes [ ] No Hormone Replacement? [ ] Yes [ ] No

Women: Do you think you may be pregnant? [ ] Yes [ ] No

Height \_\_\_\_\_ ft \_\_\_\_\_ in Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

Have you ever experienced the following symptoms?

- [ ] Chest Pain [ ] Chest tightness or pressure [ ] Shortness of breath
[ ] Angina [ ] Fainting

Do you take a daily aspirin? [ ] No [ ] Yes, Baby Aspirin [ ] Yes, Adult Aspirin

Please indicate cholesterol levels (if known)

HDL \_\_\_\_\_ LDL \_\_\_\_\_ Triglycerides \_\_\_\_\_ Total Cholesterol \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Do you smoke? [ ] Yes [ ] No
Former smoker: Quit [ ] Less than 1 year [ ] More than 1 year

Do you have Asthma? [ ] Yes [ ] No

Are you being treated or have you been treated for High Blood Pressure? [ ] Yes [ ] No

Do you have Diabetes? [ ] Yes [ ] No

Have you ever had a:

- Heart Attack [ ] Yes [ ] No Stroke [ ] Yes [ ] No TIA [ ] Yes [ ] No
Heart Surgery [ ] Yes [ ] No Bypass [ ] Yes [ ] No Valve [ ] Yes [ ] No
Stent [ ] Yes [ ] No Coronary Balloon (PTCA) [ ] Yes [ ] No

Treadmill Test/Nuclear/Stress Echo [ ] Yes [ ] No If yes, Year \_\_\_\_\_ [ ] Normal [ ] Abnormal

Angiogram/Cardiac Cath [ ] Yes [ ] No If yes, Year \_\_\_\_\_ [ ] Normal [ ] Abnormal

Prior EBT Scan [ ] Yes [ ] No If yes, Year \_\_\_\_\_ [ ] Normal [ ] Abnormal

If yes to prior EBT Scan, where? \_\_\_\_\_

