Medical City Las Colinas

CALCIUM SCORING QUESTIONNAIRE

Name: _____ **Age:** _____ **Date:** _____

Gender

- ☐ **Male**
- ☐ **Female**

Height: _____ **Weight:** _____

Have you ever experienced the following symptoms:

- ☐ **Chest Pain**
- ☐ **Chest Pain**
- ☐ **Chest Tightness/Pressure**
- ☐ **Shortness of Breath**
- ☐ **Angina**
- ☐ **Fainting**

Do you take aspirin daily?

- ☐ **Yes**
- ☐ **No**

If yes, how many mg: _____

Please indicate cholesterol levels, if known:

Indicator	Level
HDL	
LDL	

Triglycerides	
Total Cholesterol	
BP	

Do you smoke?

- ☐ **Yes**
- ☐ **No**

Former smoker?

- ☐ **Yes**
- ☐ **No**

If yes, how many years? _____

Do you have asthma?

- ☐ **Yes**
- ☐ **No**

Are you being treated or have you ever been treated for high blood pressure?

- ☐ **Yes**
- ☐ **No**

Do you have diabetes?

- ☐ **Yes**
- ☐ **No**

Have you ever had:

Heart attack	☐ **yes**	☐ **no**
Stroke	☐ **yes**	☐ **no**
TIA	☐ **yes**	☐ **no**
Heart Surgery	☐ **yes**	☐ **no**
Bypass	☐ **yes**	☐ **no**
Valve Surgery	☐ **yes**	☐ **no**

Stent	☐ **yes**	☐ **no**			
Coronary Balloon	☐ **yes**	☐ **no**			
Treadmill Test/Nuclear/Stress Echo	☐ **yes**	☐ **no**	**Year:**	☐ **normal**	☐ **abnormal**
Angiogram/Cardiac Cath	☐ **yes**	☐ **no**	**Year:**	☐ **normal**	☐ **abnormal**

				Heart Disease		
	Stroke	**Hypertension**	**Diabetes**	**Before 55 (65 for female)**	**Before 55 (65 for female)**	**Abnormal Cholesterol**
Parent	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐
Grandparent	☐	☐	☐	☐	☐	☐

Please list medications or vitamins you are presently taking (or attach list):

Medication/Vitamin	Dosage	Frequency

Allergies: _____

Current Physician: _____ **Phone #** _____ **Fax #** _____

Patient Signature: _____ **Date:** _____

Print Name: _____

Technologist Signature: _____ **3-4 ID:** _____ **Date:** _____