South Denver Cardiology Associates, P.C.

Calcium Heart Score Questionnaire

Name: ____ Date:______/_______/__20_____

Medical Records #:___________________________

Birthdate:________/_______/_______ Age:________ (Please circle): Female Male

Weight:___________________lbs. Height: __________feet _________inches

Cholesterol (Amounts if known): LDL: _________________ HDL: ________________ Triglycerides: ____________

Blood Pressure:_____________________________________ Diabetes: Y / N Year Diagnosed: __________

Current Smoker: Y / N Packs (per day): _____________ Years (how many): _________

Former Smoker: Y / N Packs (per day): _____________ Years (how many): __________ Year Quit: __________

Are you currently taking (Please circle): Adult Aspirin Baby Aspirin Anti-oxidant

MEDICATIONS (Please list):

____ ____

____ ____

____ ____

____ ____

MEDICATION ALLERGIES:____

____

Have you ever had X-Ray dye: Y / N Any reaction for X-Ray dye, Iodine, or shellfish: ___________________

MEDICAL HISTORY (Please check all that apply):

- ❑ Hypertension
- ❑ Arrhythmia
- ❑ Previous Heart Attack
- ❑ Previous Bypass Surgery
- ❑ Previous Angioplasty
- ❑ Cancer (Please specify type):
- ❑ Previous Stent Placement
- ❑ Stroke

ADDITIONAL MEDICAL HISTORY: ____

____

PREVIOUS CARDIAC TESTING:

❑ EKG	❑ Treadmill	❑ Stress Echo	❑ Angiogram	❑ Calcium Heart Score	❑ Nuclear Study
__________	__________	__________	__________	__________	__________
Year	Year	Year	Year	Year	Year

FAMILY CARDIAC HISTORY (Please check all that apply)

	Abnormal Cholesterol	Diabetes	Hypertension	Heart Disease (Before 55)	Heart Disease (After 55)	Stroke
Father						
Mother						
Brother						
Sister						
Grandparent						

CURRENT CARDIAC SYMPTOMS (please check all that apply):

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Fainting
- ❑ Chest Pressure
- ❑ Frequent Palpitations

Physician Name: ____

Physician Phone: (_______) ____