DESERT MEDICAL IMAGING

CTA Coronary Arteries/Calcium Score Questionnaire

Name: _____ Date: _____

Height: _____ Weight: _____ Regular Exercise? _____

Referring Physician: _____

Reason for having this test: (check all that apply)
( ) Baseline/Screening (No previous history or symptoms)
( ) Family history of coronary/heart disease Father Mother Siblings
( ) High blood pressure – On high blood pressure medication? Yes No
( ) History of diabetes - On diabetes medication? Yes No
( ) High cholesterol – On cholesterol medication: Yes No
( ) History of smoking – current smoker? Yes No Stopped when? _____
( ) Concerning symptoms (chest pain, shortness of breath, tightness, jaw pain, arm pain)
( ) Recent high cardiac scoring – When? _____ What was score? _____
( ) Renal/Kidney disease – Recent blood work? When? _____ Where? _____
( ) History of atrial fibrillation or arrhythmia? Yes No
( ) Other reason not listed _____

Have you ever been treated for a cardiac/heart condition? Yes No
If yes, when? _____What was the treatment? _____

Have you ever had a cardiac catheterization? Yes No
If yes, when? _____ Where? _____

Have you ever had a coronary balloon angioplasty or stent? Yes No
If yes, which vessels? _____

Have you had open heart bypass surgery? Yes No
If yes, when? _____ Where? _____
How many bypasses? _____

Have you ever had a valve replacement? Yes No
If yes, which ones? () Mitral () Aortic () Tricuspid
Surgeon's name: _____ May we request your records? Yes No

Are you currently on dialysis? Yes No (Dialysis should be scheduled within 2 hrs after exam)
Are you allergic to iodine? Yes No
Allergy to any medications? Yes No If yes, please list _____
Females – Are you pregnant? Yes No

Have you followed the prep instructions listed below for this exam? Yes No
1. No food, milk or orange juice 4 hours prior to examination
2. No caffeine 24 hours prior to examination
3. Drink 32 ounces of water prior to examination

_____ _____
Patient Signature Date