

WESTSIDE CARDIOVASCULAR MEDICAL GROUP

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Nuclear Cardiology Patient Questionnaire

First Name: _____ Last Name: _____

Acc #/MRN: _____ Date of Birth: _____

Exam #: _____ Study Date: _____

Referring MD: _____ Pt. Phone #: _____

cc MD 1: _____ cc MD 2: _____

Gender: M F Age: ____ Ht : ____ (in), Wt: ____ (lbs) Bra Size: ____ Cup: ____

Have you ever had a heart attack? No Yes if yes, date and year _____

Have you ever had an angioplasty? No Yes if yes, date and year _____

Have you had open-heart surgery? No Yes if yes, date and year _____

Do you have Hypertension? No Yes Do you have a Pacemaker? No Yes

Do you have Diabetes? No Yes Do you smoke? No Yes

Do you have High Cholesterol? No Yes

Do you have Family History of Heart Disease (before age 55)? No Yes

Do you have or have you recently had: Chest or other pain/pressure? No Yes

Do you have or have you recently had: Other (jaw, neck, throat, arm, back)? No Yes

Does your symptom occur at rest? No Yes

Does your symptom occur with exertion? No Yes

Are your symptoms relieved with nitroglycerin? No Yes

Are your symptoms relieved with rest? No Yes

What medication do you currently take?

Medication	Dose	Last Taken

Do you have asthma? No Yes

Have you had caffeine within the past 24 hour? No Yes

If yes, please indicate what and when? _____