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ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

Patient History

Name: _____ Date: _____ DOB: _____

Reason for Visit _____ Ref: Physician: _____

CARDIAC SYMPTOMS	Y	N	How long
Chest Pain or angina.....			
Left arm pain/numbness.....			
Palpitations (fast heart beat).....			
Shortness of breath (walking/lying flat).....			
Swelling of feet, ankles or hands.....			
Lightheadedness, dizziness, or fainting.....			
Leg Pain …….....			
Cramping in legs at night……			
Weight Gain/ Loss……			
PAST MEDICAL HISTORY			
Heart Attack /MI …….....			
Coronary artery Bypass surgery /Stent..…			
Heart Valve Surgery……...			
Pacemaker/ICD..... .			
Congestive Heart Failure/ CHF.....			
Irregular Heart Beat/ Arrhythmias/A fib….			
Heart Murmur / Valve Disease.....			
Congenital Heart Disease			
High Blood Pressure.....			
High Cholesterol.....			
Blockage in leg (PVD) / Blood clot			
Diabetes Type I or ÌI.....			
Stroke / Mini-Stroke / TIA.....			
Bleeding Tendencies.....			
Kidney Trouble.....			
Backache/Arthritis / Gout.....			
Lung Diseases / Asthma.....			
Sleep Apnea.....			
Other Disease.....			

Surgical History:

_____
_____
_____
_____
_____

Previous Diagnostic test:

Echocardiogram.....Y / N Date: _____
Nuclear..... .....Y / N Date: _____
Stress or Treadmill Test…….Y / N Date: _____
Carotid U/S:.....Y / N Date: _____
Holter Monitor……Y/ N Date: _____
Other test..... Y / N Date: _____

ALLERGY Reactions:

Contrast Dye.....Y / N _____
Iodine, or shell fish.....Y / N _____
Drugs / Medications _____
_____

SOCIAL HISTORY:

Marital Status: Single / Married / Divorced / Widowed

Use of Tobacco: Never / Prev. quit in _____Amount:___

Use of Alcohol: Never / Moderate / Daily _____

Use of Drugs: Never / Type of drug / How often _____

Use of Caffeine: Never / Moderate / Daily Amount:_____

Exercise: Never / Moderate / Daily Type:_____

MEDICATIONS: **DOCTOR**

Name of Medicine (currently taking)	Dosage	NAME	SPECIALTY
1.		1	
2.		2	
3.		3	
4.		4	

Please let us know your pharmacy name and phone# _____
_____
_____
_____