New York Private Medical Imaging LLP

CARDIAC SCORING SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Weight?			Height?
Are you a smoker?	☐YES	☐NO	If you quit, how long ago:
Family history of CAD (coronary artery disease)?	☐YES	☐NO	If YES, what age:
History of heart attack?	☐YES	☐NO	If YES, what age:
Family history of heart attack?	☐YES	☐NO	If YES, what age:
Do you exercise daily?	☐YES	☐NO	Frequency of exercise (per week):
History of blood pressure?	☐YES	☐NO	
If you are not on medication, is your blood pressure normally over 140/90?	☐YES	☐NO	☐UNKNOWN
History of high cholesterol?	☐YES	☐NO	Is it greater than 200?: ☐YES ☐NO ☐UNKNOWN
History of diabetes?	☐YES	☐NO	
Are you taking any medicine for high cholesterol, blood pressure or diabetes?	☐YES	☐NO	

SCREENED BY: SCREENED WITH:

Technologist comments:

Technologists initials:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /