

Patient History – Coronary Artery Calcium Scoring (CACs) Heart Scan General Information

Patient Name _____
Address _____
City _____ State _____ Zip _____
E-Mail Address _____ Social Security Number _____
Home Phone # _____ Cell Phone # _____
Date of Birth _____ Age _____ Sex _____
Date of Scan _____

Insurance Information (for billing purposes only)

Patient's Employer _____ Phone # _____
Responsible Party (if different from above) _____
Name of Subscriber _____ Relationship _____
Subscriber's Employer _____
Subscriber's Date of Birth _____ Social Security Number _____

Medical History Referring Physician / Organization _____
Phone # _____

Have you recently had any of the symptoms or conditions listed below?

| | | | |
|--|--------------------|-------------------------------------|--------------------|
| Chest Pain / Pressure at Rest | Yes _____ No _____ | Chest Pain / Pressure with Exertion | Yes _____ No _____ |
| Fainting or Light-headedness | Yes _____ No _____ | Fast Heart Rate | Yes _____ No _____ |
| Unusual Fatigue | Yes _____ No _____ | Diabetes / High Blood Sugar | Yes _____ No _____ |
| High Blood Pressure | Yes _____ No _____ | Irregular Heart Rhythm | Yes _____ No _____ |
| Most recent blood pressure - Systolic Pressure _____ | | Diastolic Pressure _____ | Date Checked _____ |

Please answer the following questions about your family disease history:

| | Heart Attack | Stroke | Diabetes | High B/P | Cancer | If deceased, Age at Death |
|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------------|
| Father | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sibling (M) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Sibling (F) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Grandparents | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Please provide the following information about your blood lipids (cholesterol) if available:

| | | | | |
|---|-------------|--------------------------------|---------------------------------------|-----------|
| Cholesterol | (Treated) | Total Cholesterol Level _____ | HDL _____ | LDL _____ |
| High <input type="checkbox"/> OK <input type="checkbox"/> | (Untreated) | Total Cholesterol Level _____ | HDL _____ | LDL _____ |
| Triglycerides | (Treated) | Total Triglyceride Level _____ | What year last measured? _____ | |
| High <input type="checkbox"/> OK <input type="checkbox"/> | (Untreated) | Total Triglyceride Level _____ | | |

Have you ever had any of the following medical studies?

Resting Electrocardiogram (ECG) Yes _____ No _____ Normal _____ Abnormal _____ Year _____
 Treadmill (ECG) Stress Test Yes _____ No _____ Normal _____ Abnormal _____ Year _____
 Echocardiogram of the Heart Yes _____ No _____ Normal _____ Abnormal _____ Year _____
 Thallium Study of the Heart Yes _____ No _____ Normal _____ Abnormal _____ Year _____
 Cardiac Catheterization (Heart Cath) Yes _____ No _____ Normal _____ Abnormal _____ Year _____
 Balloon Angioplasty Yes _____ No _____ Year _____
 Atherectomy Procedure (Roto-rooter) Yes _____ No _____ Year _____
 Coronary Stent Placement Yes _____ No _____ Year _____

If any of the imaging studies marked above have occurred in the last 2 years, where was the study done, and do you have a copy of the report? If so, please bring them with you. _____

Have you ever had any of the following? When were they first diagnosed?

Heart Attack Yes _____ No _____ Year _____
 Stroke Yes _____ No _____ Year _____
 Coronary Artery Disease Yes _____ No _____ Year _____
 Aortic Aneurysm Yes _____ No _____ Year _____
 Cancer Yes _____ No _____ Year _____
 Other Yes _____ No _____ Year _____

Please answer the following questions about your personal and exercise habits:

Do you currently use tobacco? Yes _____ How many packs per day? _____
 Have you used tobacco in the past? Yes _____ How many packs per day? _____
 If so, how many years? _____ If yes, how many years since you quit? _____
 If so, how many years? _____ If yes, how many years since you quit? _____

Are you currently involved in a routine of regular exercise at least 3 days a week for a duration of 15-20 min.?

Yes _____ No _____ Do you participate in weight training? Yes _____ No _____ If so, how long have you been participating? < 1 year? _____ 1 to 2 years _____ 2 to 10 years _____ > 10 years _____ Current Weight _____ Height _____

Do you have a history of "allergy-like" reactions to contrast media which requires treatment? Yes _____ No _____

Do you take aspirin daily? Yes _____ No _____ If so, what dosage? _____ If so, how long? _____

Is there any chance of pregnancy? Yes _____ No _____

Please list all current medications you are taking (prescription and over-the-counter) and check the category for which they are prescribed. Also list any meds you have discontinued in the last two weeks.

| Drug Name | Heart | Arrythmias | Blood Pressure | Cholesterol Lowering | Stomach | Other | Number of Years |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|
| 1. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Signature _____ Date _____

Patient authorizes Washington Imaging Services, LLC (WIS) to obtain professional radiology interpretations from Overlake Imaging Associates, PC or it's designee (OIA), a separate entity. A portion of the billing may represent fees due to OIA for OIA's services.