

CARDIAC CTA MEDICAL HISTORY FORM

Name Last _____ First _____ M.I. _____
 Date of Birth ____ / ____ / ____ Age ____ RA # _____
 Height _____ Weight _____ Sex M F

Please mark the appropriate answers:

	<u>Yes</u>	<u>No</u>		
<u>Your Risk Factors</u>				
Current Smoker	___	___	If so, how many years?	_____
Former Smoker	___	___	If so, how many years?	_____
Diabetes	___	___	If so, do you take insulin?	_____
High Blood Pressure	___	___	If so, how high?	_____
Overweight	___	___		
Heart Disease in Family	___	___	If so, who?	_____
High Cholesterol	___	___	If so, how high?	_____
High Triglycerides	___	___	If so, how high?	_____

<u>Your Symptoms</u>				
Chest Pain or Pressure	___	___	If so, what details?	_____
Upper Back Pain	___	___	If so, what details?	_____
Shortness of Breath	___	___	If so, what details?	_____

<u>Your Heart History</u>				
Coronary Artery Disease	___	___	If so, what details?	_____
Heart Attack	___	___	If so, what details?	_____
Heart Valve Disease	___	___	If so, what details?	_____
Heart Arrhythmia	___	___	If so, what details?	_____
Congestive Heart Failure	___	___	If so, what details?	_____
Other Heart or Lung Disease	___	___	If so, what details?	_____

<u>Prior Heart Tests</u>				
Treadmill Stress Test	___	___	If so, what details?	_____
Nuclear Stress Scan	___	___	If so, what details?	_____
Echocardiogram	___	___	If so, what details?	_____

<u>Prior Heart Procedures</u>				
Coronary Angioplasty	___	___	If so, what details?	_____
Coronary Stent Placement	___	___	If so, what details?	_____
Bypass Surgery (CABG)	___	___	If so, what details?	_____
Other Heart Surgery	___	___	If so, what details?	_____
Pacemaker or Defibrillator	___	___	If so, what details?	_____

Current Heart Medications _____

Signature _____ Date _____



CARDIAC CTA WORKSHEET

Patient Name _____

<u>Yes</u>	<u>No</u>	<u>CTA Contraindications</u>
___	___	Atrial fibrillation or other major arrhythmia
___	___	Contrast allergy
___	___	Kidney Disease Cr _____ GFR _____ Date _____

		<u>Beta-Blocker Contraindications</u>
___	___	High grade heart block
___	___	Significant CHF
___	___	Significant asthma / theophylline for COPD

		<u>Nitroglycerin Contraindications</u>
___	___	Vigra, Cialis, or Levitra in past 24 hours
___	___	Nitroglycerin / nitrate allergy

		<u>Other</u>
___	___	Caffeine in past 12 hours
___	___	Exercise in past 24 hours
___	___	Metformin for diabetes (Glucophage, Glucovance, Avandamet, Metaglip)
___	___	Previous contrast study (CT, IVP, angiogram)

Scan Details

HR on Arrival	_____	Blood Pressure on Arrival	_____
HR during Scan	_____	Blood Pressure before Scan	_____

Oral Metoprolol	_____	Visipaque 320 Amount	_____
Nitroglycerin	_____	Expires _____ Lot	_____

Radiation DLP	_____	Scan Delay	_____
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Injection Site R Antecubital _____ L Antecubital _____ Other _____

Adverse Reactions Headache _____ Other _____

Comments _____

 Technologists / Aides

 Date

