CALCIUM SCORING CT SCAN
PATIENT INFORMATION

DATE	PATIENT NAME		MR#
WEIGHT	DOB	REFERRING DR:	

1. Prior cardiac surgery or **stents**	YES**	NO	
2. Personal history of hypertension	YES	NO	
3. Family history of heart disease	YES	NO	
4. Personal history of diabetes	YES	NO	
5. Obesity	YES	NO	
6. Smoker	YES	NO	Ex-smoker
7. Personal history of high cholesterol	YES	NO	
8. Pulmonary Disorders	YES	NO	
9. Alcohol	YES	NO	
10. History of Chest Pain?	YES	NO	
Typical Angina	YES	NO	
Atypical Angina	YES	NO	
Stable Angina	YES	NO	
Unstable Angina	YES	NO	
11. History of myocardial infarction (heart attack)	YES	NO	
12. Dyspnea (shortness of breath)	YES	NO	
13. History of cancer?	YES	NO	

14. In the last 12 months how many CT scans have you had?

15. In the last 12 months how many myocardial perfusion scans have you had?

**Not a candidate for this exam if stents are present and/or prior cardiac surgery has been performed.