

**CT CORONARY SCREENING**

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| **THIS SECTION TO BE COMPLETED BY PATIENT** | | | |
| **NAME:** | | | **DOB:** |
| Are you pregnant or possibly pregnant? | Yes | | No |
| Are you currently a smoker? | Yes | | No |
| If yes, how many packs per day? | | | |
| Have you ever had heart surgery? | Yes | | No |
| Have you ever had a cardiac catheterization? | Yes | | No |
| Have you ever been diagnosed with high blood pressure? | Yes | | No |
| Have you ever been diagnosed with high cholesterol levels? | Yes | | No |
| Do you have a personal history of heart disease? | Yes | | No |
| If yes, please explain: | | | |
| Do you have a close blood relative with heart disease? | Yes | | No |
| If yes, please explain relation: | | | |
| **ARE YOU CURRENTLY EXPERIENCING:** | | | |
| Chest pain | Yes | | No |
| Shortness of breath upon exertion | Yes | | No |
| Please describe any other symptoms you are experiencing: | | | |
|  | | | |
| **Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **MDI Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

6/26/18