

CARDIAC PATIENT QUESTIONNAIRE

Name:		Date:	
Height (in.):		Medical Record #	
Weight (lbs.):		or Date of Birth:	

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

HISTORY

Why are you having this study?

☐ Abnormal Stress Test ☐ Chest Discomfort ☐ Shortness of Breath ☐ Other: _____

If other, please specify: _____

Do you have a personal history of the following?

Diabetes or medication for diabetes? ☐ Yes ☐ No

High blood pressure or medication for blood pressure? ☐ Yes ☐ No

High cholesterol or medication for high cholesterol? ☐ Yes ☐ No

Parents or siblings with heart attacks before age 60? ☐ Yes ☐ No

None of the above ☐

Do you currently have any of the following?

Congestive Heart Failure? ☐ Yes ☐ No

Coronary Stent? ☐ Yes ☐ No

Heart bypass surgery? ☐ Yes ☐ No

Pacemaker or defibrillator implant? ☐ Yes ☐ No

Atrial Fibrillation (AFIB)? ☐ Yes ☐ No

Severe aortic stenosis? ☐ Yes ☐ No

Hypertrophic obstructive cardiomyopathy (HOCM) ☐ Yes ☐ No

Taking Phosphodiesterase 5 inhibitors (PDE5-I) such as Viagra (sildenafil), Cialis (tadalafil),

Levitra (vardenafil) ☐ Yes ☐ No

None of the above ☐ Yes ☐ No

Smoking Status?

☐ Current Smoker ☐ Past Smoker ☐ Never Smoked