

## MRI: Cardiovascular Form

(Office use)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MRN #: \_\_\_\_\_

Gender: ☐ Female ☐ Male Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other \_\_\_\_\_

Has a doctor ever said that you have high blood sugar? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

If yes, for approximately how many years have you been treated for this: \_\_\_\_\_

Has a doctor ever told you that you have high blood pressure? ☐ Yes ☐ No

Do you take medication to lower your blood pressure? ☐ Yes ☐ No

Have you ever smoked at least 1 pack cigarettes/month? ☐ Yes ☐ No

Are you smoking cigarettes now? ☐ Yes ☐ No

Has a doctor ever told you that you have high cholesterol? ☐ Yes ☐ No

Do you currently take medication to lower your cholesterol? ☐ Yes ☐ No

Have any of your children, brothers, sisters, or parents been diagnosed with heart disease (coronary artery disease) when younger than 55 years old (men) or 65 years old (women)?

☐ Yes ☐ No ☐ Unknown

Have you ever been told by a doctor that you had a stroke? ☐ Yes ☐ No

If yes, dates: \_\_\_\_\_

Have you ever been told by a doctor that you had a mini-stroke or "TIA"? ☐ Yes ☐ No

If yes, dates: \_\_\_\_\_

Do you take aspirin daily? ☐ Yes ☐ No

Has a doctor ever told you that you had a heart attack? ☐ Yes ☐ No

If yes, list dates (month/year): \_\_\_\_\_

Have you ever had an angioplasty or heart stent? ☐ Yes ☐ No

If yes, list dates (month/year): \_\_\_\_\_

Hospital (if known): \_\_\_\_\_

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Have you ever had coronary artery bypass (CABG) surgery? ☐ Yes ☐ No

If yes, list dates (month/year): \_\_\_\_\_

Hospital (if known): \_\_\_\_\_

Have you ever had heart valve surgery? ☐ Yes ☐ No

Have you ever had atrial fibrillation? ☐ Yes ☐ No

If yes, did it last for more than 7 days? ☐ Yes ☐ No

Did it require medications or cardioversion for treatment? ☐ Yes ☐ No

Have you experienced two or more episodes of atrial fibrillation? ☐ Yes ☐ No

Do you experience chest pain, shortness of breath, marked fatigue, or palpitations ("heart fluttering") with the following:

Ordinary daily activities ☐ Yes ☐ No

Less than ordinary activity ☐ Yes ☐ No

Unable to carry out any physical activity without symptoms ☐ Yes ☐ No

Please list all the medications that you take at home:

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### **IF PHYSICIAN COMPLETING:**

#### MEDICATIONS (outpatient)

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Beta blocker                 | <input type="checkbox"/> ACE Inhibitor | <input type="checkbox"/> ARB                   | <input type="checkbox"/> Statin  |
| <input type="checkbox"/> Ezetimibe (Zetia)            | <input type="checkbox"/> HCTZ          | <input type="checkbox"/> Loop Diuretic         | <input type="checkbox"/> Nitrate |
| <input type="checkbox"/> Aldactone                    | <input type="checkbox"/> Digoxin       | <input type="checkbox"/> Niacin                | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Thienopyridine (clopidogrel) | <input type="checkbox"/> Warfarin      | <input type="checkbox"/> Bile acid sequestrant |                                  |

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### CHF SEVERITY\*

- ☐ NYHA I no limitation/ordinary activity doesn't cause undue fatigue, dyspnea, angina, palpitations
- ☐ NYHA II comfortable at rest/ordinary activity results in fatigue, dyspnea, angina, palpitations
- ☐ NYHA III comfortable at rest/less than ordinary activity causes fatigue, dyspnea, angina, palpitations
- ☐ NYHA IV symptoms at rest/unable to carry out any physical activity without, symptoms

\*symptoms as outpatient (i.e. during week prior to admission)

### ATRIAL FIBRILLATION

- ☐ NONE
- ☐ PAROXYSMAL AF Spontaneous episodic termination (generally <7. days, typically <1 day)
- ☐ PERSISTENT AF Sustained (typically >7 days or requiring cardioversion)
- ☐ PERMANENT AF Longstanding without intermittent sinus rhythm (typically > 1 year)

Two or more episodes of atrial fibrillation? ☐ Yes ☐ No