



HEART CHECK Los Angeles

Heart Scan Health Risk Questionnaire

For Office Use Only:

- CACS: _____
 LUNGS: _____
 ABD/PEL: _____
 QCT BD: _____
 V.C.: _____

Scanning Tech: _____

Appointment Date: ____/____/____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Social Security Number (optional): _____-_____-_____

Gender: M F Present height? _____ ft. _____ in. Present weight? _____ pounds

Street Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: (____)____-____-____ Alternate #: (____)____-____-____

E-Mail Address: _____

Please note for speed of transmittal your report and itemized statement will be E-mailed to you.

Referring Physician's Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____)____-____-____ Fax: (____)____-____-____

CHOLESTEROL

Have you been diagnosed with high cholesterol?

- No Yes → Treated Untreated **TRIG:** Known Value: _____

HDL: Known Value: _____

- I don't know
 Low
 Normal
 High

LDL: Known Value: _____

- I don't know
 Low
 Normal
 High

TOTAL CHOL: Known Value: _____

- I don't know
 Normal
 High

Cholesterol Medication

- None**
 Statin: Lipitor, Mevacor, Pravachol, Lescol, Zocor, Crestor; etc.
 Niacin: Niaspan
 Bile acid Sequestrants: Colestid, Welcol, Questran
 Fibric Acid deriv: Lopid, Tricor
 Other: Zetia, Vytorin

BLOOD PRESSURE

Have you been diagnosed with hypertension or elevated Blood Pressure?

- No
 Yes → How many years ago? _____
 Treated Untreated

Blood Pressure Values:

Current reading: _____ over _____

| | <u>SBPmm/Hg</u> | | <u>DBPmm/Hg</u> |
|------------------------------------|-----------------|------|-----------------|
| <input type="checkbox"/> Low | <120 | over | <80 |
| <input type="checkbox"/> Normal | 120-139 | over | 80-89 |
| <input type="checkbox"/> High | 140-159 | over | 90-99 |
| <input type="checkbox"/> Very High | >160 | over | >100 |

Blood Pressure Medications

- None**
 ACE/Alpha Receptor Blockers: Lotensin, Captopril, Vasotec, Zestril/Lisinopril, Accupril, Altace, Mavik, Univas
 Alpha Antagonist: Prazosin/Minipress, Terazosine/Hytrin, Docaxocine/Cardura
 Diuretics: HCTZ, Lasix, Maxide, Bumex, Triamterene, Spironalactone
 Calcium Channel Blockers: Calan/Verapamil, Diltiazam/Cardizem, Dilacor, Tiazac; Norvasc; Procardia; Nifedipine, Plendil/Felodpine
 Beta blockers: Inderal, Atenolol/Tenormin, Metoprolol/Lopressor, Toprol, Kerlone, Corgard]
 Other: Coreg/Trandate, Ziac, Hyzaar, Diovan/HCT, Catapres, Apresoline, Diupress, Tarka, Lotrel, Cozaar, Avalide

CARDIAC SYMPTOMS

- Shortness of Breath
- Chest Pain
- Heartburn
- Chest Tightness
- Abnormal EKG
- Chest Pressure
- Frequent Palpitations
- Unusual Cough
- Syncope/Fainting Spells
- Fatigue/Dizziness
- Known Heart or Cardiovascular Disease
- Malaise
- NONE

SMOKING HISTORY

- Non-smoker
 - Former Smoker –
 - Current Smoker –
- How many packs a day do you smoke? _____
- How many years have you smoked? _____

DIABETES

- Have you been diagnosed with having Diabetes?**
- No
 - Yes → How do you control your condition?
 - Oral medication
 - Insulin

CORONARY / CARDIAC PROCEDURES

- None
- Angiogram /Angioplasty [PTCA] # of STENTS
 - Placed _____
 - Location _____
- Open Heart Surgery [CABG]
 - # of grafts _____
 - Location _____
- Other _____

FAMILY HISTORY

- Unknown History
- No Family History
- Adopted

| | <u>Stroke</u> | <u>Hypertension</u> | <u>Diabetes</u> | <u>Heart Disease before 55</u> | <u>Heart Disease After 55</u> |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------------|-------------------------------|
| Father/Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brother/Sister | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Grandparent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

MEDICATIONS

- None
- Daily Aspirin
- Antioxidants
- Other {Please list all medications/supplements}

EXERCISE:

Current level of exercise:
Please pick one that fits you best.

- Unable to quantify
- None
- Less than 30 min. 2-3 times a week
- 30-45 min 2-3 times a week
- 45-60 min. 2-3 times a week
- More than 60 min. 2-3 times a week

STRESS:

Current level of Lifestyle Stress:
Please pick one that fits you best.

- Unable to quantify
- Low
- Average
- Above Average
- High
- Very High