SJRA

SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Calcium Scoring Patient History Form

Exam date _____

Patient name _____ DOB _____

○ Female ○ Male Height _____ Weight _____

1. Do you have or have you been treated for the following:
   - ☐ Heart surgery
   - ☐ Pacemaker
   - ☐ Stents
   - ☐ Heart bypass
   - ☐ Heart block
   - ☐ Irregular heart rhythm
2. Is there any history of heart disease in your family? ○ **Y** ○ **N**
3. Do you have Diabetes? ○ **Y** ○ **N**
4. Do you have a history of smoking? ○ **Y** ○ **N**
5. Do you exercise? ○ **Y** ○ **N** If yes, how many times per week _____
6. Are you presently taking cholesterol medication? ○ **Y** ○ **N**
7. What is your cholesterol blood level? _____
8. What is your HDL level? _____
9. What is your LDL level? _____
10. What is your triglyceride level? _____
11. Do you see a cardiologist? ○ **Y** ○ **N**

    If yes, specify cardiologist _____

FOR OFFICE USE ONLY

Blood Pressure: _____

Pulse: _____