CT HEART - CALCIUM

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____ _

DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

*** **Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.** ***

WEIGHT:

□ Yes □ No – Are you currently experiencing any symptoms?

If yes, please describe: _____

□ Yes □ No – Do you have a history of any of the following (please circle):

pacemaker, heart stents, heart bypass, heart block, irregular heart rhythm, diabetes

□ Yes □ No – Do you take cholesterol medication?

□ Yes □ No – Do you exercise? If yes, what and how often? _____

□ Yes □ No – Is there a history of heart disease in your family?

□ Yes □ No – Do you smoke or have you ever been a smoker? If yes and you have quit, when? _____

If known, please provide the following information: Total cholesterol level in the blood: _____

HDL level: _____

LDL level: _____

Triglyceride level: _____

□ Yes □ No – Do you see a cardiologist? If yes, who (please print)? _____

□ Yes □ No – Do you have a cardiac pacemaker or defibrillator?

FOR WOMEN: Date of last menstrual period: _____

Are you pregnant or think you could be? □ Yes □ No Have you had a hysterectomy? □ Yes □ No

Are you using any form of birth control? □ Yes □ No ---------- If yes, list: _____

TECHNOLOGIST USE ONLY

Comments: _____

_____

_____ CT Technologist:_____Ext:_____

I attest that the information on the form above, including technologist comments above, is correct and complete to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: _____ **Date:** _____

If Form Completed by Someone Other than the Patient (Print name):_____

Relationship: _____