WASHINGTON
RADIOLOGY
ASSOCIATES, P.C.

CARDIAC SCORING

Patient Questionnaire

Acct # ________________________ Tech's Init./Exam Date ________/________

Name ________________________ DOB ________________ Sex ________

Referring Physician(s) ____

Please list all prescription medications you are currently taking ________________________

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Risk Factors:

- ○ Yes ○ No Family HX CAD ________________________________
- ○ Yes ○ No HTN
- ○ Yes ○ No Increased cholesterol
- ○ Yes ○ No Exercise ________________________________
- ○ Yes ○ No Low fat diet ________________________________
- ○ Yes ○ No Diabetes
- ○ Yes ○ No HX of Smoking: Current ____________ Former ____________
- ○ Yes ○ No Obesity

Height ____________ Weight ____________

Symptoms:

- ○ Yes ○ No Dyspnea
- ○ Yes ○ No Angina

Cardiac History:

- ○ Yes ○ No Arrhythmia
- ○ Yes ○ No Previous MI
- ○ Yes ○ No Vascular surgery

Washington Radiology Associates, P.C.

Cardiac Scoring

Patient Questionnaire Continued...

○ Yes ○ No HX of related thoracic disorders ______________________________

○ Yes ○ No Other ______________________________

○ Yes ○ No Pregnant

If no, Date/LMP: ______________________________

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Patient Signature Date