



CARDIAC SCORING

For Office Use Only
Place Patient ID label here

Patient name _____ Female Male

Reason for exam _____ Exam date _____

Please list all medications you are currently taking _____

RISK FACTORS

- Y N Family history of CAD (Coronary Artery Disease) _____
- Y N Hypertension
- Y N Increased cholesterol
- Y N Exercise _____
- Y N Low fat diet _____
- Y N Diabetes
- Y N History of smoking Current Former
- Y N Obesity
- Height _____ Weight _____

SYMPTOMS

- Y N Dyspnea (difficulty breathing/shortness of breath)
- Y N Angina (chest pain)

CARDIAC HISTORY

- Y N Arrhythmia (irregular heart rhythm)
- Y N Previous MI (Myocardial Infarction)
- Y N Vascular surgery (surgery to arteries or veins)
- Y N History of related thoracic disorders _____
- Y N Other _____

For female patients only:

- Y N Are you pregnant?
- If not, date of last menstrual period _____

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Remarks: _____

Technologist: _____ Date: _____