Cedars Sinai
S. Mark Taper Foundation
Imaging Center

CARDIAC IMAGING QUESTIONNAIRE

PATIENT I.D.

Age: _____ Sex: ❑ Male ❑ Female

Demographics: What is your ethnicity?

❑ African American ❑ Native American ❑ Caucasian
❑ Asian/Pacific Islander ❑ Hispanic/Latino ❑ Other, specify: _____

The following body measurements help in the interpretation of your test results

Height: _____ inches Weight: _____ pounds

Medical History

1. Have you had any **caffeine-containing** beverages, foods or medicines (*including soda, energy drinks, coffee, decaffeinated coffee, tea, chocolate, cocoa, Excedrin, etc.*) within the **past 24 hours**?
   ❑ No ❑ Yes—please specify products: _____
2. Have you ever been told you have **asthma** or another chronic respiratory disease?
   ❑ No ❑ Yes—please specify name(s) of condition: _____
3. Is this test being done as part of a **pre-op** evaluation for surgery?
   ❑ No ❑ Yes—please specify type of surgery: _____
4. Are you allergic to **iodine contrast**?
   ❑ No ❑ Yes

Symptoms

Important: If you have had bypass surgery, angioplasty or a heart attack in the last 12 months, describe any discomfort since then.

1. Chest Pain/Discomfort:

Have you had pain or discomfort above your waist in the last 12 months

❑ No ❑ Yes—If "Yes":

a. Approximately how long have you had this pain or discomfort? _____

b. Does the pain/discomfort occur mostly in the center of your chest? ❑ No ❑ Yes

If not, which of the following locations describe most of your discomfort?

❑ Left side of the chest ❑ Left arm ❑ Neck or jaw ❑ Other, specify: _____

c. Does the pain/discomfort occur commonly with physical exertion? ❑ No ❑ Yes
If "yes," does the pain/discomfort most often go away within 10 minutes with rest? ❑ No ❑ Yes

d. Does the pain/discomfort go away with nitroglycerin? ❑ Never taken ❑ No ❑ Yes

e. Has this pain or discomfort been getting worse during the last month (*i.e., more often, more severe or intense, or lasting longer*)? ❑ No ❑ Yes

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Symptoms (continued)

2. Shortness of Breath:

a. Have you had unusual shortness of breath in the last 12 months? ❑ No ❑ Yes

b. Do you have shortness of breath during physical exertion? ❑ No ❑ Yes

c. Have you had worsening shortness of breath during the last month (*i.e., more often, more severe or intense, or lasting longer*)? ❑ No ❑ Yes

3. Other Symptoms:

Have you had any of the following in the last 12 months?

Palpitations ❑ No ❑ Yes

Fainting, syncope (*blackouts*) ❑ No ❑ Yes

Cardiac History

1. Have you ever had the following:

a. Heart attack (*myocardial infarction*)? ❑ No ❑ Yes

Date of most recent (MM-DD-YY): _____-_____-_____

Location (Hospital, City, State): _____

b. Cardiac catheterization for a coronary angiogram? ❑ No ❑ Yes

Date of most recent (MM-DD-YY): _____-_____-_____

Location (Hospital, City, State): _____

c. Coronary angioplasty (*balloon or stent*)? ❑ No ❑ Yes

Date of most recent (MM-DD-YY): _____-_____-_____

Location (Hospital, City, State): _____

d. Congenital heart disease (*problems with your heart chamber/valves, "holes" or "murmur" in the heart*)? ❑ No ❑ Yes

Describe type of congenital heart disease: _____

e. Heart surgery?

Date of most recent (MM-DD-YY): _____-_____-_____

Location (Hospital, City, State): _____

What type of heart surgery did you have? Mark all that apply.

❑ Bypass surgery ❑ Valve surgery ❑ Heart transplant ❑ Other: _____

❑ Congenital (*describe repair*): _____

f. Pacemaker? ❑ No ❑ Yes

g. Defibrillator (*ICD*)? ❑ No ❑ Yes

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Cardiac History (continued)

2. Have you ever been told by a healthcare practitioner that you have:

a.	High blood pressure (*hypertension*)	❑ No	❑ Yes
b.	High cholesterol	❑ No	❑ Yes
c.	Diabetes	❑ No	❑ Yes
d.	A heart valve problem	❑ No	❑ Yes
e.	Cardiomyopathy	❑ No	❑ Yes
f.	Atrial flutter or fibrillation	❑ No	❑ Yes
g.	Heart failure	❑ No	❑ Yes
h.	Stroke or TIA (*transient ischemic attack*)	❑ No	❑ Yes
i.	Renal (*kidney*) failure of dysfunction	❑ No	❑ Yes
j.	Autoimmune disease	❑ No	❑ Yes
k.	Sleep apnea	❑ No	❑ Yes
l.	Chronic obstructive pulmonary disease (*COPD*)	❑ No	❑ Yes
m.	Cancer	❑ No	❑ Yes

3. Do you experience a cramping pain in your calves when you walk, which your doctor has called **peripheral arterial disease** or claudication? ❑ No ❑ Yes

4. Do you currently or have you **ever** smoked cigarettes?
❑ No ❑ Yes—If "Yes":

   a. How many years did you smoke? _____

   b. How many **packs per day** on average? ❑ Less than ½ pack ❑ ½ to 1 pack ❑ More than 1 pack

   c. Have you stopped smoking? ❑ Yes – specify date stopped (MM-DD-YY): _____-_____-_____
   ❑ No, have not stopped smoking

5. Please list any other **serious medical problems:** ❑ None

_____

_____

6. Females:

Are you postmenopausal?	❑ No	❑ Yes
If "yes," are you taking estrogen replacement?	❑ No	❑ Yes

Family History of Heart Disease

Do you have any close blood relative(s) who developed coronary heart disease **before age 55 for male relatives or before 65 for female relatives** (*e.g., child, parents, siblings, grandparents*)?

❑ No ❑ Yes—specify how many: _____ ❑ Don't know

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Exercise and Diet

Circle one number only that best answers each question

		Never									Every day
a.	How much do you exercise?	0	1	2	3	4	5	6	7	8	9	10
b.	How much does the status of your heart limit your day-to-day physical activities?	0	1	2	3	4	5	6	7	8	9	10
c.	How much does the status of your heart limit your emotional wellbeing?	0	1	2	3	4	5	6	7	8	9	10
d.	To what extent are you on a low saturated fat diet?	Very high fat 0	1	2	3	4	5	6	7	8	9	Very low fat 10

Medications

Are you taking any of the following medications? Check all that apply.

- ❑ **ACE inhibitors** (Captopril/capoten, Quinapril/accupril, Lisinopril/zestril, Ramipril/altace, Benazepril/lotensin, Monopril/fosinopril)
- ❑ **ARBs** (Losartan/cozaar, Hyzaar, Avapro/irbesartan, Diovan/valsartan, Telmisartan/micardis, Altacand/candesartan, Olmesartan/benicar, Eprosartan/teveten)
- ❑ **Aspirin** (Bayer, Ecotrin)
- ❑ **Beta blockers** (propranolol, atenolol, timolol, sotalol)
- ❑ **Calcium channel blockers** (Novasc/amlodipine, Cardizem, Tiazac/diltiazem, felodipine, verapamil)
- ❑ **Cholesterol drugs** (ezetimibe, PCSK9 inhibitors [Repatha, Praluent], statins [Lipitor/atorvastatin, Crestor/rosuvastatin], Vascepa)
- ❑ **Diuretic** (Midamor/amiloride, Bumex/bumetanide, Diuril/chlorothiazide)
- ❑ **Hormone replacement therapy**
- ❑ **Niacin**
- ❑ **Nitrates** (i.e., nitroglycerin, nitrolingual)
- ❑ **Oral diabetic medications or insulin**
- ❑ **Other chest pain medications** (blood thinner, thrombolytic drug [Eminase/anistreplase, Retavase/reteplase])
- ❑ **Other platelet inhibitors** (i.e., Plavix/clopidogrel, Aggrenox/dipyridamole, Brilinta)
- ❑ **Other blood pressure lowering drug** (Cardura, Minipress, Hytrin, methyldopa, carvedilol, Hylorel, Ismelin, Loniten)
- ❑ **I am not taking any of these medications.**

Patient name (please print)	Patient signature	Date	Time
Staff name/Title (please print)	**Staff signature**	**Date**	**Time**

For office use only:

Waist: _____ inches
Hip: _____ inches
Left BP: _____ / _____ mmHg
Right BP: _____ / _____ mmHg
HR: _____

Meds: _____

TRG	_____	md/dL
TC	_____	md/dL
GLU	_____	md/dL
HDL	_____	md/dL
LDL	_____	md/dL
VLD	_____	md/dL
TC/HDL	_____	