

**CT CORONARY SCREENING**

|  |
| --- |
| **THIS SECTION TO BE COMPLETED BY PATIENT** |
| **NAME:**  | **DOB:**  |
| Are you pregnant or possibly pregnant? | [ ]  Yes  | [ ]  No  |
| Are you currently a smoker?  | [ ]  Yes  | [ ]  No  |
| If yes, how many packs per day?  |
| Have you ever had heart surgery? | [ ]  Yes  | [ ]  No |
| Have you ever had a cardiac catheterization? | [ ]  Yes  | [ ]  No |
| Have you ever been diagnosed with high blood pressure? | [ ]  Yes  | [ ]  No |
| Have you ever been diagnosed with high cholesterol levels? | [ ]  Yes  | [ ]  No |
| Do you have a personal history of heart disease? | [ ]  Yes  | [ ]  No |
| If yes, please explain:  |
| Do you have a close blood relative with heart disease? | [ ]  Yes  | [ ]  No |
| If yes, please explain relation:       |
| **ARE YOU CURRENTLY EXPERIENCING:** |
| Chest pain | [ ]  Yes  | [ ]  No |
| Shortness of breath upon exertion | [ ]  Yes  | [ ]  No |
| Please describe any other symptoms you are experiencing: |
|  |
| **Patient or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **MDI Technologist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

6/26/18