Grossmont Medical Terrace
Outpatient Services

Name: ______________________
MRN: ______________ DOB: ____________
Referring Physician: ______________________
Date of Service: __________

Cardiac Study Flow-sheet

		(Circle One)
Have you had a previous imaging study that required an injection of contrast (dye)?	**Yes**	**No**
If **YES**, did you experience any difficulties from the contrast?	**Yes**	**No**
Are you allergic to **Iodine**, **Shellfish** or **Seafood**?	**Yes**	**No**

If **YES** to any of the above, please describe:
Patient Weight ______

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DO YOU HAVE ANY OF THE FOLLOWING ?

Asthma / Hay fever	**Yes**	**No**	If YES, do you use an inhaler? **Yes No** How often? _____
Diabetes	**Yes**	**No**	If YES, do you take Glucophage or Metformin? **Yes No**
Smoker / Smoking History	**Yes**	**No**	If YES, __ packs per day X__ years Quit:___ yrs.__months
High Cholesterol	**Yes**	**No**	If YES, do you take medication? **Yes No** LDL Level ____
Heart Disease	**Yes**	**No**	
Heart Attack	**Yes**	**No**	
Congestive Heart Failure	**Yes**	**No**	
Angina (Severe Chest Pain)	**Yes**	**No**	
Stroke	**Yes**	**No**	
Family History of Heart Disease	**Yes**	**No**	
Irregular Heart Beat / Fibrillation	**Yes**	**No**	
Pacemaker / Defibrillator	**Yes**	**No**	
High Blood Pressure / Hypertension	**Yes**	**No**	
Sickle Cell Disease	**Yes**	**No**	
Respiratory Disease or Failure	**Yes**	**No**	
Kidney Disease or Failure	**Yes**	**No**	
Prior Heart Surgery including Bypass	**Yes**	**No**	

If **YES** to any of the above, please describe: ______________________________

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MALE PATIENTS ONLY:
Have you taken any of the following medications?
in the last 36 hours?

Cialis (Tadalafil)	**Yes**	**No**
Viagra (Sildenafil)	**Yes**	**No**
Levitra (Vardenafil)	**Yes**	**No**

FEMALE PATIENTS ONLY:
Date of last menstrual cycle: ______________

I may be pregnant	**Yes**	**No**
Hysterectomy	**Yes**	**No**
Hormone Replacement Therapy	**Yes**	**No**

Post-Menopausal **Yes No** When? ________

Please list **ALL** Allergies: (Medications, Food, Other) ______________________________

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Please list **ALL** Medications you are currently taking (prescription & OTC): ____________________

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Please list **ALL** Cardiac Surgeries / Procedures (if you have a Stent, please list the location): __________

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Please list **ALL** other Surgeries: ______________________________

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Consent Signed: **Yes** **No**