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ACR American College Of Radiology

ICANL Nuclear Cardiology Accredited Nuclear Cardiology Laboratory

Have you ever smoked (or used tobacco products)? Yes No
If yes, do you now? Yes No
If yes, how much? _____
When did you start? _____
When did you stop? _____
Do you use alcohol? Yes No Occasionally
How much? _____ How often? _____
If you answer yes to any of the following questions, please state when you were diagnosed:
High Blood Pressure Yes / No _____
High Cholesterol Yes / No _____
Diabetic Yes / No _____
Ever had a heart attack Yes / No If yes, when? _____
Have you ever had any of the following: If yes, state diagnosis date or procedure date:
Ever been told you had a blockage in your legs? Yes / No _____
Ever had a procedure related to that blockage? Yes / No _____
Heart Failure Yes / No _____
History of Atrial Fibrillation? Yes / No _____
Ever had a stent? Yes / No _____
If yes, when and name of facility: _____
(mm/dd/yy) (facility)
Ever had by-pass surgery? Yes / No
If yes, when and name of facility: _____
(mm/dd/yy) (facility) Ever had a procedure related Yes / No
to your neck arteries?
If yes: right / left / both: _____
Ever had a procedure related to that problem? Yes / No
Prior amputation related to Limb Ischemia: Yes / No
Lung Problems? Yes / No
Sleep Apnea? Yes / No
If yes, CPAP / NA: _____
If yes, how many pillows do you sleep on? _____
Do you have Liver Disease? Yes / No
Do you have Kidney Disease? Yes / No
Are you a Diabetic? Yes / No
If yes, have you had eye problems because of your diabetes? Yes / No
Do you have Glaucoma? Yes / No
Do you have Macular Degeneration? Yes / No

FAMILY HISTORY

Do your parents, brother or sisters have any of the following?
Diabetes Yes / No If yes, who_____
High Blood Pressure Yes / No If yes, who_____
Stroke Yes / No If yes, who_____What Age_____
Heart Attack Yes / No If yes, who_____What age_____