



MEDICAL INFORMATION

Height _____ Weight _____

- Do you have a history of the following conditions?
- Currently pregnant? Yes No
 Number of weeks: _____
- Seizures? Yes No
 Asthma? Yes No
 Other lung diseases? Yes No
 Kidney transplant? Yes No
 Contrast-induced kidney failure? Yes No
 Multiple myeloma? Yes No
 Diabetes? Yes No
 Type I Type II
- Are you taking Glucophage (Metformin)? Yes No
 Date and time of last dose _____
- Drug allergies? Yes No
 Specify: _____

- Specific allergies:
- Shellfish? Yes No
 Iodine? Yes No
 Strawberries? Yes No
 Contrast reaction? Yes No
 X-ray dye (contrast medium) allergy? Yes No
 Specify reaction: _____
- Other allergies: Yes No
 Specify: _____
- History of cancer? Yes No
 Specify: _____
- Have you had any barium for stomach, colon, or other CT or CAT scan in the last 72 hours? Yes No
 If yes, specify: _____
- Prior surgery? Yes No
 List all: _____

- Are you presently having or have you recently (over the past 4 weeks) had any of the following symptoms:
 Chest pain, pressure, discomfort or burning Yes No
 Shortness of breath Yes No
 Difficulty breathing when lying flat Yes No
 Dizziness Yes No
 Fainting Yes No
 Irregular or skipped heart beats Yes No
 Swelling of the feet or ankles Yes No
 Fatigue or unusual tiredness Yes No
 Leg pain when walking (claudication) Yes No
- Do you have, or have you been told you have any of the following:
 Coronary artery disease Yes No
 Cardiac catheterization Yes No
 Angioplasty Yes No
 A stent Yes No
 Coronary artery bypass grafting Yes No
- Do you have, or have you been told you have any of the following:
 High blood pressure Yes No
 Diabetes? Yes No
 Type I Type II
 High cholesterol Yes No
 High triglycerides Yes No
 Erectile dysfunction Yes No
- Do you currently smoke cigarettes Yes No
 For how many years? _____
- If yes, how many packs per day? _____
- Are you an ex-smoker Yes No
 If yes, date stopped? _____
- Do you smoke cigars or a pipe? Yes No
- Do you chew tobacco Yes No
- Do you have any immediate family members who have had heart disease before the age of 60 (father, mother, brothers, sisters, grandparents)? Yes No
 If yes, when? _____

- Do you follow a low-fat diet Yes No
- Do you exercise regularly Yes No
 If yes, what type of exercise and how often do you exercise?

LIST OF CURRENT MEDICATIONS

| NAME | DOSAGE | FREQUENCY | LAST TAKEN |
|------|--------|-----------|------------|
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