



Patient Name (Please Print): _____
Account Number: _____

We are asking you to complete this form only one time. This form is designed to help us meet the new requirements of the insurance policies that we are contracted with. You will only be asked to complete the form once. Please give this form to the medical technician that brings you back to your room. Thank you in advance!

Cardiac Risk Factors:

Have you ever had or currently have: (Check all that apply) Please use space provided to write in comments where applicable.

- Taking Aspirin If yes, what dose are you taking? _____
- Alcohol Use (If yes, comment how much per day)

- Diabetes Mellitus
- Congestive Heart Failure
- Embolism (Blood Clot) if yes where was the clot?
Leg? _____
Lung? _____
- Hyperthyroidism (High Thyroid Level)
- Hypertension (High Blood Pressure)
- Hyperlipidemia (High Cholesterol)
- Physical Activity
How many times a week do you exercise? _____
What type of physical activity do you do? _____
For how many minutes? _____
No exercise? _____
- Recreational Drug Use
- Smoking History (If yes, how many packs per day and date quit) _____
- Tobacco Use (Yes/No) If yes, how often and what type _____

Has your mother, father, sister, or brother had the following (check all that apply):

- Coronary Heart Disease
- Diabetes Mellitus
- Hyperlipidemia (High Cholesterol)
- Hypertension (High Blood Pressure)

***MEDICAL RECORDS DO NOT SCAN**