



## Nuclear Medicine Patient Questionnaire

1. Why did your doctor order this test? \_\_\_\_\_
2. Who is your primary care physician? \_\_\_\_\_
3. Who is your cardiologist? \_\_\_\_\_

### Brief Health History

4. Y N Are you diabetic? If yes, how is it treated? (please check any that apply)  
Diet Oral Meds Insulin
5. Y N Do you have a family history of heart disease?
6. Y N Do you smoke? If so, how much and for how long? \_\_\_\_\_
7. Y N Have you ever smoked? If yes, how much did you smoke and for how long? \_\_\_\_\_
8. Y N Do you have high blood pressure?  
Y N If yes, are you on blood pressure medication?
9. Y N Do you have high cholesterol?  
Y N If yes, are you taking medication to lower your cholesterol?
10. Y N Do you have any lung problems such as asthma, emphysema, COPD?
11. Y N Do you have any other major health problems? If so, please list them. \_\_\_\_\_

### Cardiac History

12. Y N Have you ever been diagnosed with Congestive Heart Failure (HF)?
13. Y N Have you ever had a heart attack (MI)? When? \_\_\_\_\_
14. Y N Have you ever had a heart catheterization (angiogram)? If yes, when? \_\_\_\_\_
15. Y N Have you ever had a stent or angioplasty? If yes, when? \_\_\_\_\_
16. Y N Have you ever had bypass surgery? If yes, when? \_\_\_\_\_
17. Y N Do you have a pacemaker or defibrillator? If yes, when was it implanted? \_\_\_\_\_
18. Y N Do you have any other cardiac history? If so, please list below.  
\_\_\_\_\_

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**\*FEMALE PATIENTS\* Please complete the questionnaire for female patients.**