



ENVISION IMAGING
OF ALLEN

CARDIAC SCORING PATIENT HISTORY SHEET

Name: _____ Date: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ M / F Weight: _____

Family Physician: _____ Phone: _____

RISK FACTORS:

Hypertension? Yes _____ No _____

Diabetes? Yes _____ No _____

Smoking? Yes _____ No _____

Family History of
Heart Disease? Yes _____ No _____

High Cholesterol?
Known Yes _____ No _____

Heart Disease?
Previous Yes _____ No _____

Heart Surgery? Yes _____ No _____

FOR WOMEN:

Menopausal? Yes _____ No _____

HRT? Yes _____ No _____

(hormone replacement therapy)

SYMPTOMS:

Chest pain/pressure? Yes _____ No _____

Shortness of Breath? Yes _____ No _____

PREVIOUS TESTING:

Stress Testing? Yes _____ No _____ Results? _____

Thallium Mapping? Yes _____ No _____ Results? _____

COMMENTS: _____