WASHINGTON RADIOLOGY

For Office Use Only
Place Patient ID label here

Cardiac Scoring

RISK FACTORS

○ Y ○ N Diabetes
○ Y ○ N Hypertension
○ Y ○ N Increased cholesterol
○ Y ○ N History of smoking ○ Current ○ Former
○ Y ○ N Family history of CAD (Coronary Artery Disease) ____________
○ Y ○ N Obesity
Height ________ Weight ________ BMI ________

Reason for exam ____________ Exam date ________
Please list all medications you are currently taking ____________

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○ Y ○ N Have you had previously related studies (nuclear scan, x-ray, ultrasound, CT, MRI or PET)? If yes, please explain and bring studies to your appointment.
______ Number of prior CT and Cardiac Nuclear Medicine (myocardial perfusion) studies within the past 12 months.

Type of Exam	Where	When	Results

For female patients only:
○ Y ○ N Are you pregnant?
Date of last menstrual period ________ Patient Signature ____________

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Remarks: ____________

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Technologist/Nurse: ____________ Date: ________