

For PrevaHealth use only

Height _____

Weight _____

Blood Pressure _____

Your Doctor's Phone (if known): _____ FAX _____

Do You Take Medications to Control Your Cholesterol? No _____ If Yes _____:
 Statin: _____ Niacin: _____ Tricor: _____ Gemfibrozil or Lopid: _____ Other: _____

Do You Smoke? Never ___ Yes: _____ Packs per Day: _____ Quit _____ Packs per Day: _____
 Number of Years: _____ Number of Years: _____
 Quit When? _____

Do You Have a History of High Blood Pressure? No _____ Yes _____ Highest Values _____

Do You Take Medications to Control Your Blood Pressure? No _____ if Yes: ACE Inhibitor/A II Blocker _____
 Calcium Channel Blocker _____
 Beta Blocker _____
 Alpha Agonist _____
 Diuretic _____
 Other _____

Do You Have Diabetes? _____ If Yes, then (please check) _____
 Dietary Control: _____
 Insulin Only: _____
 Oral Medications: _____
 Insulin & Oral: _____

Do You Have Any of the Following Symptoms? (Check all that apply)

- | | |
|-------------------------|--------------------------------------|
| Chest Pain _____ | Shortness of Breath _____ |
| Chest Tightness _____ | Heartburn _____ |
| Chest Pressure _____ | Abnormal EKG _____ |
| Unusual Cough _____ | Frequent Palpitations _____ |
| Fatigue/Dizziness _____ | Syncope _____ |
| Malaise _____ | Known heart or cardiac disease _____ |

Family History of Diabetes, Stroke, or Heart Disease (please check all that apply)

Family History	Hypertension	Stroke	Diabetes	Heart Disease Below Age 55	Heart Disease Above Age 55
Parents					
Sibling					
Grandparents, Aunts, Uncles					

Have you had any of the following procedures? (If Yes, then please indicate below)

Procedure	When?
CABG (bypass surgery)	_____
Coronary Angiography (catheterization)	_____
PTCA	_____
Angioplasty/Stent	_____
EP (electrophysiology) testing	_____
Normal stress test	_____
Abnormal stress test	_____

Exercise on a Regular Basis? No ___ Yes ___

Less than 30 min. 3-5 times/week _____

30-45 minutes 3-5 times/week _____

45-60 minutes 3-5 times/week _____

More than 60 minutes 3-5 times/week _____

What is The Current Level of Stress in Your Daily Life? (Please check)

Low: ___ Average: ___ Above average: ___ High: ___ Very High ___ Unable to qualify: ___

Do You Take Aspirin on A Regular Basis? No ___ Yes ___

Current Medications (include prescribed and “over the counter” medications such as aspirin and vitamins):

Medication (trade or generic name)	Dose

Do You Have a Personal History of Heart or Peripheral Vascular Disease? No _____ Yes _____

If Yes, please indicate as follows:

Event	When
Heart Attack	_____
Angina	_____
Abnormal Heart Rhythm	_____
Heart Failure	_____
Aortic Aneurysm	_____
Other (specify)	_____

Have You Had a Prior Lung Scan? No ___ Yes (where & when) _____

Do You Have a History of Any of the Following Lung Diseases or Related Risk Factors?

Chronic bronchitis _____ Emphysema _____ Prior radiation therapy _____
 Radon Exposure _____ Asbestos Exposure _____ Lung Cancer _____
 Other _____

Have you had: Abnormal x-ray _____ Abnormal CT _____ Abnormal MRI _____ (check all that apply)

Check any of the following symptoms that you've had:

Unexplained chest pain: _____ Unexplained hoarseness: _____
 Unexplained weight lost _____ New or productive cough _____
 Blood in sputum _____ Other (specify) _____

Please Indicate Family History if known

Family History	Unknown	Emphysema	Chronic bronchitis	Lung cancer
Parents				
Siblings				
Grandparents or Aunts/Uncles				

Please indicate if you have had any of the following procedures (If Yes, then procedure and date)

Procedure	When?
Bronchoscopy	_____
Lung Biopsy	_____
Lobectomy (removal of portion of lung)	_____
Lungectomy (removal of an entire lung)	_____
Normal stress test	_____
Abnormal stress test	_____
Coronary Angiography (catheterization)	_____
Peripheral Angiography	_____
Angioplasty/Stent	_____
EP (electrophysiology) testing	_____
CABG (bypass surgery)	_____
Carotid ultrasound	_____
Abdominal ultrasound	_____
Other (specify)	_____

List Any Previous Surgeries: (with approximate dates)

The fastest vehicle for sending your final test results is email. To do so, however, we need an accurate (and legible) email address and a waiver of any potential HIPPA privacy rights.

Please email my results to me at:

_____ (email address)

I assume any HIPPA risks regarding the privacy of my email. _____ (initial)

Patient's Signature

Date Form Filled Out