

Weill Cornell Imaging

at NewYork-Presbyterian

Name: _____ Date of Birth: _____ MRN #: _____

Gender: _____ Female _____ Male Height: _____ Weight: _____

Race/Ethnicity: _____ Caucasian _____ African American _____ Hispanic _____ Asian _____ Other

Has a doctor ever said that you have high blood sugar? Yes No
 Do you have diabetes? Yes No
 If yes, for approximately how many years have you been treated for this: _____

Has a doctor ever told you that you have high blood pressure? Yes No
 Do you take medication to lower your blood pressure? Yes No

Have you ever smoked at least 1 pack cigarettes/month? Yes No
 Are you smoking cigarettes now? Yes No

Has a doctor ever told you that you have high cholesterol? Yes No
 Do you currently take medication to lower your cholesterol? Yes No

Have any of your children, brothers, sisters, or parents been diagnosed with heart disease (coronary artery disease) when younger than 55 years old (men) or 65 years old (women)?
Yes No Unknown

Have you ever been told by a doctor that you had a stroke? Yes No
 If yes, dates: _____

Have you ever been told by a doctor that you had a mini-stroke or "TIA"? Yes No
 If yes, dates: _____

Do you take aspirin daily? Yes No

Has a doctor ever told you that you had a heart attack? Yes No
 If yes, list dates (month/year): _____

Have you ever had an angioplasty or heart stent? Yes No
 If yes, list dates (month/year): _____
 Hospital (if known): _____

Have you ever had coronary artery bypass (CABG) surgery? Yes No
 If yes, list dates (month/year): _____
 Hospital (if known): _____

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|---|-----|----|
| Have you ever had heart valve surgery? | Yes | No |
| Have you ever had atrial fibrillation? | Yes | No |
| If yes, did it last for more than 7 days? | Yes | No |
| Did it require medications or cardioversion for treatment? | Yes | No |
| Have you experienced two or more episodes of atrial fibrillation? | Yes | No |

Do you experience chest pain, shortness of breath, marked fatigue, or palpitations ("heart fluttering") with the following:

| | | |
|--|-----|----|
| Ordinary daily activities | Yes | No |
| Less than ordinary activity | Yes | No |
| Unable to carry out any physical activity without symptoms | Yes | No |

Please list all the medications that you take at home:

IF PHYSICIAN COMPLETING:

MEDICATIONS (outpatient)

| | | | |
|------------------------------|---------------|-----------------------|---------|
| Beta blocker | ACE Inhibitor | ARB | Statin |
| Ezetimibe (Zetia) | HCTZ | Loop Diuretic | Nitrate |
| Aldactone | Digoxin | Niacin | Aspirin |
| Thienopyridine (clopidogrel) | Warfarin | Bile acid sequestrant | |

CHF SEVERITY*

NYHA I no limitation/ordinary activity doesn't cause undue fatigue, dyspnea, angina, palpitations

NYHA II comfortable at rest/ordinary activity results in fatigue, dyspnea, angina, palpitations

NYHA III comfortable at rest/less than ordinary activity causes fatigue, dyspnea, angina, palpitations

NYHA IV symptoms at rest/unable to carry out any physical activity without, symptoms

*symptoms as outpatient (i.e. during week prior to admission)

ATRIAL FIBRILLATION

NONE

PAROXYSMAL AF Spontaneous episodic termination (generally <7. days, typically <1 day)

PERSISTANT AF Sustained (typically >7 days or requiring cardioversion)

PERMANENT AF Longstanding without intermittent sinus rhythm (typically > 1 year)

Two or more episodes of atrial fibrillation? Yes No