Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122
Please bring all completed forms to your appointment

(Office use)

MRI: CARDIOVASCULAR FORM

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): _____

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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): _____

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:

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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