

*(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): \_\_\_\_\_

Have you ever had an angioplasty or heart stent?       Yes       No

If yes, list dates (month/year): \_\_\_\_\_

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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:

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### **IF PHYSICIAN COMPLETING:**

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### MEDICATIONS (outpatient)

- |   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> Beta blocker                 | <input type="checkbox"/> ACE Inhibitor | <input type="checkbox"/> ARB                   | <input type="checkbox"/> Statin  |
| <input type="checkbox"/> Ezetimibe (Zetia)            | <input type="checkbox"/> HCTZ          | <input type="checkbox"/> Loop Diuretic         | <input type="checkbox"/> Nitrate |
| <input type="checkbox"/> Aldactone                    | <input type="checkbox"/> Digoxin       | <input type="checkbox"/> Niacin                | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Thienopyridine (clopidogrel) | <input type="checkbox"/> Warfarin      | <input type="checkbox"/> Bile acid sequestrant |                                  |

### CHF SEVERITY\*

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> NYHA I   | no limitation/ordinary activity doesn't cause undue fatigue, dyspnea, angina, palpitations    |
| <input type="checkbox"/> NYHA II  | comfortable at rest/ordinary activity results in fatigue, dyspnea, angina, palpitations       |
| <input type="checkbox"/> NYHA III | comfortable at rest/less than ordinary activity causes fatigue, dyspnea, angina, palpitations |
| <input type="checkbox"/> 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

- |  |
|--|
| <input type="checkbox"/> NONE  |
| <input type="checkbox"/> PAROXYSMAL AF Spontaneous episodic termination (generally <7. days, typically <1 day) |
| <input type="checkbox"/> PERSISTANT AF Sustained (typically >7 days or requiring cardioversion)                |
| <input type="checkbox"/> PERMANENT AF Longstanding without intermittent sinus rhythm (typically > 1 year)      |

Two or more episodes of atrial fibrillation?  Yes  No