

(office use)

MRI: CARDIOVASCULAR FORM

Name: _____ Date of Birth: _____ MRN: _____

Gender: Female Male Height (in.): _____ Weight (lbs.): _____

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)

- | | | | |
|---|--|--|----------------------------------|
| <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*

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

- 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

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