# Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

*Please complete MRI General Safety Form in addition to this form*

*(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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## MRI: CARDIOVASCULAR FORM

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*

*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