HOAG MEMORIAL HOSPITAL PRESBYTERIAN

STRESS TEST QUESTIONNAIRE

Patient Name: _____ Height: _____ Weight: _____

Please check yes or no:

Have you ever had:	Yes	No	Date of Most Recent:
Heart Attack	☐	☐	_____
Heart Cath	☐	☐	_____
Angioplasty/Stent	☐	☐	_____
Bypass graft	☐	☐	_____
Valve Replacement	☐	☐	_____
Treadmill stress test	☐	☐	_____
Nuclear Stress test	☐	☐	_____

Have you recently had:	Yes	No		Yes	No
Chest Discomfort	☐	☐	Pain around back	☐	☐
Pain in left side of chest	☐	☐	Pain with emotional stress	☐	☐
Pain in neck or jaw regions	☐	☐	Palpitations	☐	☐
Pain which awakes you at night	☐	☐	Rapid or racing heart beat	☐	☐
Pain with exercise	☐	☐			

Do you have:					
High Cholesterol	☐	☐	Rheumatic Heart Disease	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Any chest injuries	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐			

Family History:

Has anyone in your immediate family (parent, siblings, or grandparents) had a heart attack (Coronary Artery Disease)? ☐ Yes ☐ No If yes, how many family members? _____

What is your exercise pattern?

☐ No exercise ☐ Light (walking, golf) ☐ Moderate (Jogging) ☐ Heavy (Running, sports)

How often? _____

Have you ever smoked? ☐ Yes ☐ No If yes, how many packs per day? _____

If you have stopped, how long ago? _____

_____ _____ _____ A.M./P.M.

[Patient/Legal Representative] [Date] [Time]

_____ _____

[If signed by other than patient, indicate relationship] [Witness]

PATIENT HEALTH HISTORY
Radiology/Cardiology Department

PS 4248 Rev 01/15/20

[2050]

Original – Chart Copy - Department