STRESS TEST QUESTIONNAIRE

Radiology/Cardiology Department

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	☐	☐	_____
Any implanted device (pacemaker, defibrillator, etc.)	☐	☐	_____

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 heartbeat	☐	☐
Pain with exercise	☐	☐			

Do you have:					
High Cholesterol	☐	☐	Rheumatic Heart Disease	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Any chest injuries	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐	Aortic Aneurysm	☐	☐
Aortic Stenosis	☐	☐	Left bundle branch block	☐	☐

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? _____

Do you plan to travel within the next week? ☐ Yes ☐ No

Patient/Legal Representative: _____ Date: _____ Time: _____AM/PM

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____ Time: _____AM/PM