MCVS
MARYLAND
CARDIOVASCULAR
SPECIALISTS

Stress Test Patient Questionnaire

Name:_____ Referring Physician:_____

Date of Birth: ___/___/___ Home Phone: (____) _____ Cell Phone: (____) _____

Cardiologist: _____ Date of Surgery (if applicable) ___/___/_____

Please answer the following: Do you have (If yes, please describe):

Yes No High blood pressure? _____
Yes No High cholesterol? _____
Yes No Diabetes? _____
Yes No Lung or respiratory disease? (Asthma or COPD)? _____
If yes, do you use inhalers? _____
Yes No Congestive heart failure? _____
Yes No History of tobacco use? _____
If yes, _____# of packs per day? For _____# of years.
Yes No Family history of heart disease? _____
If yes, who? _____
Age of the event? _____
Yes No History of kidney failure requiring dialysis? _____

Have you ever had (please circle and explain):

Yes No Heart attack? _____
Yes No Heart surgery? Bypass? _____
Yes No Valve replacement? When? _____
Yes No Stroke or TIA? _____
Yes No Pacemaker placement? When?_ _____
Yes No Cardiac catheterization/ Stent placement? _____
_____
Yes No Have you had a treadmill test before? When? _____

Have you recently had any of the following symptoms?

Yes No Chest pain or pressure? _____
Yes No Shortness of breath? _____
Yes No Palpitations or irregular heartbeats? _____
Yes No Fainting or dizziness? _____
Yes No Heart murmur? _____
Yes No Leg or calf pain when walking? _____

Ladies Only: Is there any chance that you are currently pregnant or breastfeeding? Yes/No

Thank you for taking time to answer these questions. Please feel free to ask a technologist or the Physician Assistant any questions that you may have about this study.