

NUCLEAR CARDIOLOGY

Patient Name _____ **Weight** _____ **Implants** _____
Height _____ **Bra Size** _____
Sex _____
Allergies _____ **Age** _____

Reason for Exam _____

Medical History _____

Immediate Family History of Heart Problems? _____

Have You Had Or Been Treated For The Following:

| | | |
|--------------------------------|---------------------------|--------------------------|
| _____ Chest Pain | _____ Angioplasty(s) | _____ Arrythmia |
| _____ Chest Pressure | _____ Year(s) | _____ Tachycardia |
| _____ Chest Tightness | _____ SOB | _____ (Fast Heartbeat) |
| _____ C.A.D. | _____ Do you Smoke? | _____ Brachycardia |
| _____ Tingling in Arms | _____ How much? | _____ (Slow Heartbeat) |
| _____ Tingling in Jaw/Neck | _____ Asthma | _____ Pacemaker |
| _____ Tingling in Shoulders | _____ Liteheaded | _____ Previous NM Stress |
| _____ Heart Attack(s) | _____ Dizziness | _____ Test |
| _____ Open Heart Surgery(s) | _____ Diabetes | _____ Year(s) |
| _____ If so, how many by-pass? | _____ High Blood Pressure | _____ Other |
| _____ Year(s) | _____ Low Blood Pressure | |
| _____ Cathetherizations | _____ High Cholesterol | |
| _____ Approx. Year(s) | _____ Palpitations | |

Medications _____

Beta Blockers _____

Resting Dosage _____

Persantine Stress _____ mg

Stress Dosage _____

Patient Exit Survey _____ mR/hr

Injection site _____

Started by _____

Date
