NAME _____**DATE OF BIRTH** _____
REFERRING PHYSICIAN _____
PRIMARY PHYSICIAN _____

For all answers that are *YES* Please Circle

Have you had…?

1. Prior heart attack or Cardiac catheterization
2. Pacemaker implant
3. Diabetes
4. High blood pressure
5. High cholesterol
6. Kidney problems
7. History of smoking
8. Family history of heart disease

Do you have any of the following symptoms?

1. Chest pain
2. Shortness of breath with activity
3. Shortness of breath lying down
4. Swelling in the legs
5. Irregular heartbeat or palpitations
6. Blacking out

Carotid screening:

1. Prior history of Carotid disease or surgery
2. Prior history of stroke
3. Transient double vision or blindness
4. Transient slurry speech
5. Fainting spells or blacking out
6. Weakness / numbness in one side of the body or face
7. Migraine
8. Gait disturbances

Peripheral Arterial Disease screening:

1. Prior history of peripheral vascular disease
2. Prior history of leg bypass grafting
3. Prior history of Aortic Aneurysm
4. Pain in the calves, thighs or buttocks with activity
5. Leg or foot ulcers
6. Cold or numb legs and feet

Sleep Apnea screening:

1. I have already been diagnosed with sleep apnea.
2. I snore during sleep.
3. I have been told that I stop breathing during sleep.
4. I have been told to "toss and turn" frequently and be restless all night.
5. I sweat excessively during my sleep.
6. My sleep is interrupted and I tend to wake up frequently during the night.
7. After a full night sleep, in the morning I don't feel well rested.
8. During the day, I feel sleepy and tend to fall asleep in inappropriate times.

Have you had an allergic reaction to iodine or intravenous dye?_____

Are you allergic to any food or drug? _____
_____
_____
_____

Medications:_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Surgery:_____
_____
_____
_____
_____
_____

Do Not Write Below: For Office Use Only