SANFORD HEALTH

SANFORD HEALTH
CCTA Patient Information

Patient Name: _____ ***Date:*** _____

Referring Physician: _____ ***Physician Phone #:*** _____

1. Do you have a history of heart disease? Yes _____ No _____
   If ***Yes***, please explain _____
2. Do you have high blood pressure? Yes _____ No _____
3. Do you have high cholesterol? Yes _____ No _____
4. Do you have diabetes mellitus? Yes _____ No _____
   If ***Yes***, do you take metfomin or glucophage? Yes _____ No _____
5. Do you or have you used tobacco? Yes _____ No _____
   If ***Yes***, how much and for how long? _____
6. Is there a family history of heart disease? Yes _____ No _____
7. Do you have a history of kidney disease? Yes _____ No _____
8. Are you allergic to iodine or x-ray contrast Yes _____ No _____
9. Do you have asthma? Yes _____ No _____
10. Do you have a pacemaker? Yes _____ No _____
11. Do you use any medications for erectile dysfunction such as Viagra, Cialis, Levitra or any alpha blocking agents for your prostrate such as Hytrin? Yes _____ No _____
12. Do you have symptoms of chest pain, shortness of breath or dizziness? Yes _____ No _____
    If ***Yes***, please explain _____
13. Do you have a heart murmur? Yes _____ No _____
14. Are you allergic to medication? Yes _____ No _____
    If ***Yes***, what are those medications? _____
15. Who is your primary care physician? _____