HeartCam™
Preventive Heart Care Center

A Service Provided in Collaboration with PENN Cardiac Care at Presbyterian Medical Center
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PATIENT INFORMATION

Name ____ Exam Date_____/_____/________
(Last Name) (First Name)

Date of Birth_______/_______/_________ Age______Height *(feet)*______*(Inches)*_____ Weight *(Lbs)* ________

Gender: ق Male ق Female *If Female, Post menopausal* ق YES ق NO Email________________

Address____ Phone Number______________________
(Street)

____
(City) (State) (Zip code)

Referring Physician_______________________________________ Is this your Cardiologist? ق YES ق NO

Physician Office Address________________________________ Phone Number______________________
(Street)

____
(City) (State) (Zip code)

1. How did you hear about this test? *(Check all that apply)*

   ق Doctor ق Friend ق Radio ق TV ق Mailer ق Other

2. Do you have, or have you ever been told you have High Cholesterol? ق YES ق NO
   Please indicate levels if you know them in the space provided below.

   HDL ___________ LDL____________ Triglycerides ___________ Total Cholesterol____________

3. Are you currently taken cholesterol-lowering drugs? ق YES ق NO Name of Drug ______________

4. Do you smoke? قNO قYES Packs per day _____ Years____ق FORMER SMOKER ق< 1Year ق>1 year

5. High Blood Pressure? ق YES ق NO Latest BP_____/_________ Highest BP______/_______

   Number of years ________Have you ever been treated in the past for High Blood Pressure ق YES ق NO

6. Are you Diabetic? قNO قYES If yes: ق INSULIN ق ORAL MEDICATIONS

7. Have you ever experienced the following symptoms?
   ق Chest Pain ق Chest Tightness ق Unusual Cough ق Shortness of Breath ق Chest Pressure

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ق Frequent Palpitations ق Angina

8. Have you had any of the following?

A Heart Attack	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Known Heart Disease	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Heart Murmur	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Abnormal Electrocardiogram	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Abnormal Treadmill Test	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Angiogram / Cardiac Cath	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Prior EBT Heart Scan	ق YES ق NO	Year____________	ق Normal	ق Abnormal
Heart Surgery / Bypass	ق YES ق NO	Year____________		
PTCA (Balloon Surgery)	ق YES ق NO	Year____________		
Valve Surgery	ق YES ق NO	Year____________		
Stent Placement	ق YES ق NO	Year____________		

9. Has any member of your family listed below had any of the following medical conditions?

Family	*Stroke*	*Hypertension*	*Diabetes*	*Heart attack before 55*	*Heart attack after 55*
Parent	ق	ق	ق	ق	ق
Sibling	ق	ق	ق	ق	ق
Grand Parent	ق	ق	ق	ق	ق

10. Do you exercise regularly? ق YES ق NO

If ***YES***, please indicate your exercise. ق Less than 30 mins 2-3 times/week ق30-45 mins 2-3 times/week

ق 45-60 mins 2-3 times/week ق More than 60 mins 2-3 times/week

11. Indicate your current stress level ق Low ق Average ق Above average ق High ق Very High

12. Have you ever had cancer? ق YES ق NO If YES, please indicate type____________________

13. Please list any medications or vitamins you are presently taking.

MEDICATION / VITAMIN	Dosage	Frequency

**** For Women, Please inform the Technologist if you think you may be pregnant!***