Date of test: _____ / _____ / _____

GXT/ SE/ DE/ Cnst Dr:_____

Place of birth: _____

Employment: _____

Single/Married/Divorced/Widowed (circle one)

# of children: _____

Please list any medications you are currently taking: (If you brought your medications, we'd be happy to complete this for you)

Medication	Dose	Frequency

Are you allergic to any medication?

_____

Do you have a drug plan? ☐ Yes ☐ No

What is your approximate height and weight?

Height: _____ Weight: _____

What are your cardiac risk factors?

1. Have you ever smoked? ☐ Yes ☐ No If yes, how many per day? _____Did you recently quit, when? _____
2. Do you have diabetes? ☐ Yes ☐ No How long? _____
3. Do you have high blood pressure? ☐ Yes ☐ No ☐ Don't know
4. Do you have high cholesterol? ☐ Yes ☐ No ☐ Don't know
5. Do you consume alcohol? ☐ Yes ☐ No How many drinks per week? _____
6. Do you have any first degree (parents, siblings) relatives who have had angina, heart attack(s), or a stroke at an age less than 65 years?

If so: Relation	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*****Please complete both sides of page*****

Your health history:

Please list any previous operations/significant illnesses/hospital stays

Date	Operation/Illness/Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____

Reason for visit: (Leave blank any areas that do not apply to you)

1. What is your present complaint?

☐ Chest discomfort ☐ Dizziness/light-headedness

☐ Shortness of breath ☐ Palpitations ☐ Other: _____

2. How long ago did your symptoms start? What does the discomfort feel like (sharp, pressure, tightness, etc)?

_____

_____

_____

3. Is there a pattern or a cause for your symptoms (with exertion, eating, at random, etc)? How long does an episode last (seconds, minutes, hours)?

_____

_____

_____

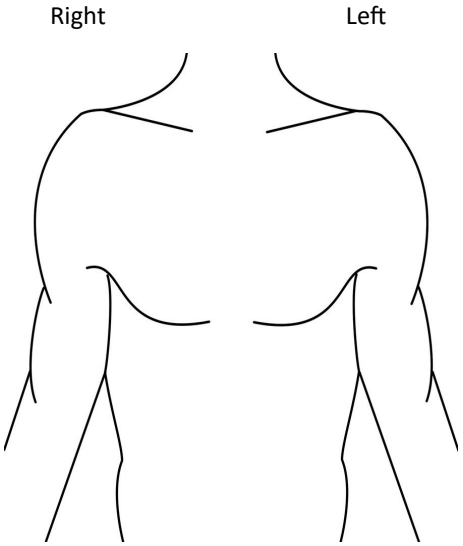
4. Is there anything that helps relieve your symptoms?

_____

_____

_____

5. Please indicate on the diagram the location of your symptoms.



Consent:

Although exercise testing is a very safe procedure, adverse reactions including, but not limited to, chest pain, arrhythmia, and heart attack have been reported and can be expected to occur at a rate of up to 1 per 10 000 tests.

The test will be stopped by the technologist or physician if you are having significant difficulty and will be stopped immediately anytime at your request.

I understand fully what is involved and the risk. My signature acknowledges my voluntary consent to perform the test.

Signed: X _____ Date: _____

Print Name: _____

Please complete both sides of page ⇨