Cardiac Perfusion Scan Questionnaire
Nuclear Medicine Clinic

Patient Name _____ **Date of Birth** _____
Weight _____ **Height** _____ **Chest Devices** _____
Pregnant Y or N **Breastfeeding** Y or N **Breast Implants** Y or N **Breast Cup Size**_____

Local phone number where we can reach you, if needed today or tomorrow _____

- What time did you last eat? _____
- What have you had to drink in the last 24 hours besides water? _____

	YES	NO
• Have you ingested any chocolate (candy, brownies, pudding, cookies, etc.) in the past 12 hours (if >100 lbs.), 24 hours (if ≤ 100 lbs.)?	☐	☐
• Have you taken Anacin, NoDoz, Excedrin, or Vivarin within the past 12 hours (if >100 lbs.) 24 hours (if ≤ 100 lbs.)?	☐	☐
• Do you take any medications containing aminophylline? (Examples: Theo-Dur, Theo-Sav, theophylline, Respid, Fioricet, Fiorinal)	☐	☐
• Can you walk on a treadmill?	☐	☐
• Do you have lung problems for which you take inhalers on a regular basis?	☐	☐
• Do you have high cholesterol or taking cholesterol medication?	☐	☐
• Do you have high blood pressure or take blood pressure medication?	☐	☐
• Do you have diabetes?	☐	☐
• Are you having chest pain today?	☐	☐
• Do you have lung problems for which you take inhalers on a regular basis?	☐	☐
• Have you had a previous nuclear medicine study? (date: _____)	☐	☐
• Do you or have you ever smoked? If you quit smoking, when did you quit? _____	☐	☐
• Have you ever had a coronary angiogram? (A procedure which a dye is injected into the arteries that supply blood to your heart muscles) If yes, when & where? _____	☐	☐
• Have you ever had an angioplasty (PTCA) or stent placed in a coronary artery? (Your coronary arteries are the blood vessels that supply oxygen-rich blood to your heart muscle)	☐	☐
• Have you ever had heart bypass surgery? If yes, when and where? _____	☐	☐

- Please list the names of the medications that you take daily and place a check mark next to those that you have taken today:

_____

_____

_____

PLACE PATIENT LABEL HERE