



PATIENT MEDICAL HISTORY

Lifestest Medical Record # _____

Last Name _____ First _____ MI _____ Exam Date ___/___/___

Height _____ Weight (Lbs) _____ Male Female

If female, is there any chance you could be pregnant? YES NO Date of last menstrual cycle _____

Have you reached menopause? YES NO Age at menopause _____ Hysterectomy YES NO

Is this your first EBT scan? YES NO If NO, Previous Scan Date _____ Location _____

Do you have, or have you ever been told you have High Cholesterol? YES NO

HDL _____ LDL _____ Triglycerides _____ Total Cholesterol _____

Do you take medications to control your cholesterol? _____

If yes: Statin Niacin Tricor Gemfibrozil or Lopid Other (specify) _____

Do you smoke? YES NO Packs per day _____ #Years smoked _____

Are you a FORMER SMOKER? YES NO Quit When? _____ #Years smoked _____

Are you currently being treated for High Blood Pressure? YES NO Latest BP _____/_____

If taking medications, please indicate: Ace/AII Receptor Blocker Alpha Antagonist

Diuretics Calcium Channel Blocker Beta-Blocker Other (specify) _____

Have you been diagnosed with antihypertension? YES NO

Are you Diabetic? YES NO If yes, controlled by: Insulin Oral Medications Dietary Control

Do you have any of the following symptoms? (Please check all that apply)

- Chest pain Sharp chest pain Stabbing chest pain Chest ache Burning in chest
- Pressure in chest Tightness in chest Shortness of breath Indigestion Heartburn Pain in arm
- Sharp pain in arm Arm ache Pressure in arm Burning in arm Tightness in arm Neck pain
- Sharp neck pain Neck ache Burning in neck Pressure in neck Tightness in neck Denies all

In the past six months, have you had: (Please check all that apply)

- Increased leg or ankle swelling Shortness of breath when trying to lay flat Fainting or near fainting associated with chest discomfort Heart palpitations or irregular heartbeat

If you indicated a symptom above, does this discomfort cause any limitation of daily activities? YES NO

How often do you have this discomfort? Daily 2-5 times per week Once a week Rarely

How long does this discomfort last? Seconds Minutes Hours Days

Is the discomfort clearly worsening? YES NO

Family History of Diabetes, Stroke, or Heart Disease (Please check all that apply)

Family History	Stroke	Hypertension	Diabetes	Heart Disease Before Age 55	Heart Disease After Age 55	Cancer
Parents						
Sibling(s)						
Grandparent/Aunt/Uncle						



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Have you had any of the following? (Please check all that apply & indicate year of occurrence)

- Heart Attack, Heart Failure, Aortic Aneurysm, Known Heart Disease, ASCVD, Angiogram, Heart Bypass Surgery (CABG), PTCA (Balloon Surgery), Coronary Angiogram, Abnormal Echo, Abnormal EKG, Abnormal Stress Test, Stent Placement

Do you exercise on a regular basis? YES NO If YES, how often _____

What is your current level of stress? Low Average Above Average High

Have you ever had cancer? YES NO

If YES, please indicate type _____ Treatment Chemo Radiation Surgery

List any surgeries you have had _____

Do you take Aspirin on a regular basis? YES NO If YES, dosage: _____

Current Medications (include prescribed and "over the counter" medications)

Table with 2 columns: Medication (trade or generic name), Dose

Any allergies to medications? YES NO Please list _____

Please provide any additional information you feel is relevant to the interpretation of your exam.

Horizontal lines for additional information

Patient's Signature

Date