CT Patient Screening for Calcium Heart Score

Please Answer the Questions Below Yes or No

Height: _____ Weight:_____

1. **Do you have history of Diabetes?** ___Yes ___No
2. **Are you a smoker or have a history of smoking?** ___Yes ___No
3. **Do you have a personal history of Heart Disease?** ___Yes ___No
4. **Do you have a family history of Heart Disease?** ___Yes ___No
5. **Do you have any stents?** ___Yes ___No
6. **Do you have a pacemaker or Automatic Internal Defibrillator?** ___Yes ___No
7. **Do you have a bypass graft?** ___Yes ___No

8. **Why are you having this CT examination? (please be specific and list your symptoms)**

_____

_____

_____ _____ _____
Patient/Parent/Legal Guardian Signature Date Time

_____ _____ _____
Witness Signature Date Time