Cardiac Care Associates

STRESS TEST QUESTIONNAIRE

NAME: ……..

DATE OF BIRTH: …….

We would appreciate your completing this questionnaire to aid in our service to you. If you have problems answering any of the questions do not hesitate to ask our technicians for help.

Why are you having this test? ……

Do you take any medications? ……If yes, what are they? .....

……

Do you have any past medical history of: **(circle correct response)**

Heart attack	Yes	No	Previous heart operation	Yes	No
Angina (chest pain)	Yes	No	Family history of heart attack or vascular disease	Yes	No
Rheumatic fever	Yes	No	High blood pressure	Yes	No
Valvular heart disease	Yes	No	High cholesterol	Yes	No
Murmurs	Yes	No	Diabetes	Yes	No
Liver problems	Yes	No	Asthma	Yes	No
Kidney problems	Yes	No			
Lung problems	Yes	No			

Do you smoke? …….. If ex-smoker, number of years since stopped ……

Do you experience any of the following symptoms? If so, could you briefly explain the nature of them.

Chest pain ……

Shortness of breath ……

Palpitations ……..

Blackouts / dizziness ……..

Ankle swelling ……

Have you had any previous cardiac investigations? Yes / No