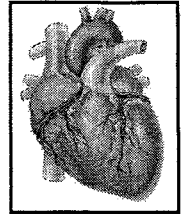


# ICMG

**Interventional Cardiology Medical Group**  
23101 Sherman Place, Suite#110, West Hills, CA 91307  
Tel (818) 702-8800 Fax (818) 702-0080



**Patient Name:** Last \_\_\_\_\_ First \_\_\_\_\_ Date: \_\_\_\_\_  
**Sex:**  Male  Female **Date of Birth:** \_\_\_\_\_ **Height:** \_\_\_\_\_ ft. \_\_\_\_\_ in. **Weight:** \_\_\_\_\_ lb.  
**Referring M.D.:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

Please answer the following questions. You may circle YES or NO or fill in the blanks.

- NO YES 1- Have you ever had a stress test? If YES, When? \_\_\_\_\_  +ve  -ve
- NO YES 2- Have you ever had a heart attack? If YES, When? \_\_\_\_\_
- NO YES 3- Have you ever had an angiogram or angioplasty? If YES, When? \_\_\_\_\_
- NO YES 4- Have you ever had a heart surgery? If YES, When? \_\_\_\_\_
- NO YES 5- Have you ever had a heart bypass surgery? If YES, When? \_\_\_\_\_
- NO YES 6- Have you ever had a breast surgery? If YES, Do you have an implant?  YES  NO
- NO YES 7- Have you ever smoked? If YES, How many years and how much? \_\_\_\_\_
- NO YES 8- Have you experienced any chest pain recently? If YES, When? \_\_\_\_\_  
How long did it last? \_\_\_\_\_  
Where in your chest did you feel the pain?  Center  Right  Left  
Was the pain related to exercise or stress?  YES  NO
- NO YES 9- Have you ever taken nitroglycerine for chest pain?
- NO YES 10- Are there any family members with heart disease? If YES, Who? \_\_\_\_\_
- NO YES 11- Have you ever been told by a physician that you have high blood pressure?  
If YES, What medication(s) do you take? \_\_\_\_\_
- NO YES 12- Have you ever been told by a physician that you have diabetes?  
If YES, What medication(s) do you take? \_\_\_\_\_
- NO YES 13- Have you ever been told by a physician that you have high cholesterol?  
If YES, What medication(s) do you take? \_\_\_\_\_
- NO YES 14- Have you ever been told by a physician that you have  asthma,  emphysema or  
 COPD? If YES, What medication(s) do you take? \_\_\_\_\_
- NO YES 15- Are you allergic to any food or medication? If YES, What? \_\_\_\_\_
- NO YES 16- Have you had any other imaging procedure during the last three days? If YES, What? \_\_\_\_\_
- NO YES 17- Can you walk fast and non-stop for six minutes or more? If NO, Why? \_\_\_\_\_
- 18- Other than mentioned above, What medications are you currently taking? \_\_\_\_\_

**Patient Signature** \_\_\_\_\_