ZILKHA RADIOLOGY – Echocardiogram Patient Form

Referring Doctor: _____

Other Doctors you want your results sent to:

_____

_____

Affix Label Here

Please answer questions below: Do you have…

YES	**NO**	Chest tightness?	**YES**	**NO**	History of fainting spells?
YES	**NO**	Chest pain?	**YES**	**NO**	Lung disease?
YES	**NO**	Palpitations?	**YES**	**NO**	Heart murmur?
YES	**NO**	Shortness of breath?	**YES**	**NO**	High Blood Pressure? Medication _____
YES	**NO**	Diabetes?	**YES**	**NO**	Enlarged heart?
YES	**NO**	If Diabetic, are you taking insulin?	**YES**	**NO**	Blood clots in legs or lungs?
YES	**NO**	High Cholesterol, How High _____	**YES**	**NO**	Smoking History? Packs per day _____
YES	**NO**	Family history heart disease?	**YES**	**NO**	Have you ever had an abnormal EKG?

Surgical History:

YES	**NO**	Cardiac catheterization? When_____	**YES**	**NO**	Aneurysm Resection? When _____
YES	**NO**	Angioplasty (PTCA)? When _____	**YES**	**NO**	Hospitalized for heart attack? When _____
YES	**NO**	Coronary Artery Bypass Grafting? When _____	**YES**	**NO**	Other Surgery _____
YES	**NO**	Heart Valve Replacement? When _____	Which Valve? _____		

Allergy to **Latex**? **YES** **NO** Reaction: _____

What symptom(s)/medical issue(s) have brought you in to visit us? _____

_____

_____

SMOKING:

☐ Current; Every Day Smoker ☐ Former Smoker ☐ Smoker; Current Status Unknown

☐ Current; Some Days Smoker ☐ Never Smoked ☐ Unknown If Ever Smoked

If Smoker, How many packs per day? _____ For how many years? _____

Are you taking any medications? NO YES List: _____

_____

_____

_____

Do you have an allergy to medications?

NO YES List: _____

_____

Authorization for Treatment: I hereby consent to treatment by the Radiologist and other medical staff for all radiological tests and/or procedures as deemed medically necessary by my referring physician.

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____Date_____