

EASTMEMPHIS
I M A G I N G

CALCIUM SCORING HISTORY FORM

Date: _____

Patient Name: _____ DOB: _____ MR# _____

Ordering physician: _____

Please answer the following questions:

Are you Diabetic? YES NO

Do you have Hypertension? YES NO

Do you have High Cholesterol? YES NO

Are you a smoker? YES NO Present Former

Any Family history of heart disease? YES NO

Any history of Chest Pain? YES NO

Chest Surgeries: YES NO

If yes, what kind? _____

Previous Exams: _____

PALP ____ SOB ____ ABN EKG ____ ABN STRESS TEST ____