Cardiac Perfusion Scan Questionnaire
Nuclear Medicine Clinic

Patient Name ___________________________________________ Date of Birth __________________________
Weight ___________________ Height ___________________ Chest Devices ______________________________
Pregnant Y or N  Breastfeeding Y or N  Breast Implants Y or N  Breast Cup Size____________________

Local phone number where we can reach you, if needed today or tomorrow __________________________

• What time did you last eat? __________________________________________________
• What have you had to drink in the last 24 hours besides water? ____________________________

YES NO
• Have you ingested any chocolate (candy, brownies, pudding, cookies, etc.) in the past
  12 hours (if >100 lbs.), 24 hours (if ≤ 100 lbs.)? -----------------------------------------------
• Have you taken Anacin, NoDoz, Excedrin, or Vivarin within the past 12 hours (if >100 lbs.)
  24 hours (if ≤ 100 lbs.)? ------------------------------------------------------------------------
• Do you take any medications containing aminophylline? ----------------------------------------
  (Examples: Theo-Dur, Theo-Sav, theophylline, Respid, Fioricet, Fiorinal)
• Can you walk on a treadmill? ---------------------------------------------------------------------
• Do you have lung problems for which you take inhalers on a regular basis? ---------------------
• Do you have high cholesterol or taking cholesterol medication? ---------------------------------
• Do you have high blood pressure or take blood pressure medication? -----------------------------
• Do you have diabetes? --------------------------------------------------------------------------
• Are you having chest pain today? __________________________________________________________
• Do you have lung problems for which you take inhalers on a regular basis? ---------------------
• Have you had a previous nuclear medicine study? (date: __________) -----------------------------
• Do you or have you ever smoked? __________________________________________________________
  If you quit smoking, when did you quit? ____________________________________________
• Have you ever had a coronary angiogram? -------------------------------------------------------
  (A procedure which a dye is injected into the arteries that supply blood to your heart muscles)
  If yes, when & where? __________________________________________________________________
• Have you ever had an angioplasty (PTCA) or stent placed in a coronary artery? ----------------
  (Your coronary arteries are the blood vessels that supply oxygen-rich blood to your heart muscle)
• Have you ever had heart bypass surgery? -------------------------------------------------------
  If yes, when and where? __________________________________________________________________
• Please list the names of the medications that you take daily and place a check mark next to those that you have taken today:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________