DIAGNOSTIC IMAGING
CENTERS, P.A.

Cardiac Calcium Scoring Form

Patient Information

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Weight: _____

Height: _____ Physician: _____

❑Male ❑Female

Medical Information

1. Do you have high blood pressure (greater than 140/90)? ❑Yes ❑No

2. Do you have diabetes? ❑Yes ❑No

3. Do you have high cholesterol levels? ❑Yes ❑No

4. **Do you have any acute chest pain or cardiac symptoms?** ❑Yes ❑No
   If yes, explain: _____

5. Do you have a history of smoking or exposure to second hand smoke? ❑Yes ❑No
   If yes, explain: _____

6. Do you have an inactive lifestyle? ❑Yes ❑No

7. Have you had previous cardiac surgery or stent? ❑Yes ❑No

8. Have you had calcium scoring with the last 2 years? ❑Yes ❑No

Patient signature: _____ **Technologist signature:**_____

For Female Patients Only

1. Date of last menstrual period: _____ Post Menopausal? ❑Yes ❑No
2. Are you pregnant or experiencing a late menstrual period? ❑Yes ❑No
3. Hysterectomy: ❑Yes ❑No
   If yes, give date: _____
4. Are you taking oral contraceptives or receiving hormonal treatment? ❑Yes ❑No

Patient signature: _____