Saint Luke's Health System

Saint Luke's Cardiovascular Consultants
Patient Information and Authorization

Full Legal Name:____

Address:______________________ City:______________ State:_____ Zip:________

Telephone: (_____)____________ Social Security Number: ______-______-________

Date of Birth:______________ Age:______ Sex: ☐ Male ☐ Female

Email address:____

Employer:______________________ Occupation:______________________

Telephone: (_____)____________ Extension:________

In an Emergency, notify:____________________ Relationship:____________________

Telephone: (_____)____________ ☐ Cell ☐ Home ☐ Work ☐ Other

♥ How did you learn about CardioScan? (check all that apply)

☐ Brochure ☐ Radio ☐ Television ☐ Newspaper ☐ Doctor ☐ Friend/Relative ☐ Health Fair

♥ Did one of our Saint Luke's Cardiologists with Cardiovascular Consultants order the Cardioscan?

☐ Yes ☐ No

♥ Did a physician refer you? ☐ Yes ☐ No

A copy of this report will be automatically forwarded to the ordering physician

♥ Is there any other physician you would like us to correspond with? ☐ Yes ☐ No

Physician's Full Name:________________________________

Telephone: (_____)____________City: ______________ State:_____ Zip:________

I hereby authorize Saint Luke's Health System to perform upon me a rapid CT scan of the coronary arteries. Furthermore, I understand that:

1. This is a limited CT scan of the chest for evaluation of coronary artery calcification only and is NOT intended for any other purpose.
2. This test does not reveal the percentage of blockage in the coronary arteries. Further cardiac testing would be required to determine that, if necessary.
3. During the course of the test, I will be exposed to radiation approximately equal to that received in a mammogram examination.
4. If I ever experience chest pain or shortness of breath, I should seek medical attention promptly, regardless of the results of this test.

Patient Name:______________________________

Patient Signature:____________________________ Date:__________ Time:__________

Patient Label:

Saint Luke's Health System

Medical Information

SLCC Chart #:____________

Patient Name______________________________
Date of Birth__________
Height _______Weight _____

Are you currently pregnant? .... Yes☐ No☐
Number of weeks: ___________

Have you had/have cancer? .... Yes☐ No☐
Specify: ____

Do you have a hiatal hernia? .... Yes☐ No☐

Prior surgery? .... Yes☐ No☐
List all: ____
____

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1. Are you presently having or have you recently (over the past 4 weeks) had any of the following symptoms:
   - Chest pain, pressure, discomfort or burning......... Yes☐ No☐
   - Shortness of breath .... Yes☐ No☐
   - Difficulty breathing when lying flat .... Yes☐ No☐
   - Dizziness .... Yes☐ No☐
   - Fainting .... Yes☐ No☐
   - Irregular or skipped heart beats........................... Yes☐ No☐
   - Swelling of the feet or ankles............................... Yes☐ No☐
   - Fatigue or unusual tiredness .... Yes☐ No☐
   - Leg pain when walking (claudication) .... Yes☐ No☐
2. Do you have, or have you been told you have any of the following:
   - Coronary artery disease .... Yes☐ No☐
   - Cardiac catheterization .... Yes☐ No☐
   - Angioplasty .... Yes☐ No☐
   - A stent.. Yes☐ No☐
   - Coronary artery bypass grafting .... Yes☐ No☐
3. Do you have, or have you been told you have any of the following:
   - High blood pressure... Yes☐ No☐
   - Diabetes?.. Yes☐ No☐
     Type I ☐ Type II ☐
   - High cholesterol .... Yes☐ No☐
   - High triglycerides .... Yes☐ No☐
   - Erectile dysfunction... Yes☐ No☐
4. Do you currently smoke cigarettes .... Yes☐ No☐
   For how many years? ________________________________
5. If yes, how many packs per day? ______________________
6. Are you an ex-smoker .... Yes☐ No☐
   If yes, date stopped? ________________________________
7. Do you smoke cigars or a pipe?.......................... Yes☐ No☐
8. Do you chew tobacco .... Yes☐ No☐
9. Do you have any immediate family members who have had heart disease before the age of 60 (father, mother, brothers, sisters, grandparents)? .... Yes☐ No☐
   If yes, when? ____
   ____
   ____
10. Do you follow a low-fat diet .... Yes☐ No☐
11. Do you exercise regularly.................................... Yes☐ No☐
    If yes, what type of exercise and how often do you exercise?
    ____
    ____
    ____

IF YOU TAKE ANY MEDICATIONS FOR CHOLESTEROL AND/OR BLOOD PRESSURE PLEASE LIST BELOW

____
____
____

Saint Luke's Cardiovascular Consultants = (SLCC)

Patient Label: