Calcium Scoring Questionnaire

Name: _____

Home Address: _____

_____

Physician Address: _____

_____

Age: _____ **DOB:** _____ **Sex:** _____ **Ethnicity:** _____

Weight: _____

Cholesterol **Blood Pressure (approximate, if known)?** _____

=LDL? _____ **Triglycerides?** _____

=HDL? _____

Diabetes? Y N (Circle answer)

Smoking? Y N (Circle answer)

If yes, how many packs? _____

Years? _____

Medications:

_____

_____

Cardiac History: _____

Family Cardiac History: _____