Stress Echocardiogram Consultation Sheet

Name: _____

Date: _____ Unit: _____

Height: _____ Weight: _____

Chief Complaint: _____

Medical History:

Chest Pain/Angina	N ☐	Y ☐	Rheumatic Heart Disease	N ☐	Y ☐
Pacemaker:	N ☐	Y ☐	Stroke / TIA	N ☐	Y ☐
Hypertension	N ☐	Y ☐	Previous MI	N ☐	Y ☐
Gastrointestinal Disease	N ☐	Y ☐	Prostate Disease	N ☐	Y ☐
Diabetes Mellitus	N ☐	Y ☐	Allergies	N ☐	Y ☐
Asthma	N ☐	Y ☐			

Prior Stress Test: N ☐ Y ☐
Date: _____

Cath/ Intervention N ☐ Y ☐
Date: _____

CABG N ☐ Y ☐
Date: _____

Prosthetic Valve N ☐ Y ☐
Date: _____

Social History:

Smoking N ☐ Y ☐
#pks per day/years _____

Alcohol N ☐ Y ☐

Narcotics/Tranquilizers N ☐ Y ☐

Family History of Heart Disease?

Mother: N ☐ Y ☐ Father: N ☐ Y ☐ Sister: N ☐ Y ☐ Brother: N ☐ Y ☐

Are you currently taking any medications? Yes No

Name of Medication	Dosage	Freqency	Taken Today?

Are you currently taking any Vitamins? Yes No

Name of Medication	Dosage	Freqency	Taken Today?