

## STRESS ECHOCARDIOGRAM CONSULTATION SHEET

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Unit: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

### Medical History:

Chest Pain/Angina	N <input type="checkbox"/> Y <input type="checkbox"/>	Rheumatic Heart Disease	N <input type="checkbox"/> Y <input type="checkbox"/>
Pacemaker:	N <input type="checkbox"/> Y <input type="checkbox"/>	Stroke / TIA	N <input type="checkbox"/> Y <input type="checkbox"/>
Hypertension	N <input type="checkbox"/> Y <input type="checkbox"/>	Previous MI	N <input type="checkbox"/> Y <input type="checkbox"/>
Gastrointestinal Disease	N <input type="checkbox"/> Y <input type="checkbox"/>	Prostate Disease	N <input type="checkbox"/> Y <input type="checkbox"/>
Diabetes Mellitus	N <input type="checkbox"/> Y <input type="checkbox"/>	Allergies	N <input type="checkbox"/> Y <input type="checkbox"/>
Asthma	N <input type="checkbox"/> Y <input type="checkbox"/>		

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

PROGRAM FOR DIAGNOSTIC AND PREVENTIVE MEDICINE

Are you currently taking any medications?

Yes  No

Name of Medication	Dosage	Frequency	Taken Today?

Are you currently taking any Vitamins?

Yes  No

Name of Medication	Dosage	Frequency	Taken Today?