STRESS TEST PATIENT QUESTIONAIRE

Name: ________________________________ **Date:** __________

1.Why are we doing your test? Symptoms: ____________________
Is this for a check-up? Yes: ______ No: ______

2. Are you able to walk on the treadmill? Yes: _____ No: _____ If no, please explain: ____

____

3. Have you had any problems with your heart? Yes: ______ No: ______
If yes, please explain: ______________________________________

____

4. Please list any medications you take: __________________________

____

____

____

5. Have you had anything to eat or drink since midnight?
Yes: ______ No: _______ Any caffeine in the past 24 hours: Coke_____
Coffee: _____ Tea: _____

6. Are you allergic to any medication? Yes: _____ No: _____ If yes, please list: ____

7. Are you sensitive to latex (i.e. gloves)? Yes: ______ No: _____
Adhesive (i.e. tape)? Yes: _____ No: _____

8. Do you use any form of tobacco? Yes: _____ No: _____ If yes, how much per day? ________________ Have you used any tobacco since midnight? __________________________ E-cigg? Yes: ____No: _____When last used? __________________________

9. Do you have any breathing problems? Yes: ______ No: _____ Do you use an inhaler or puffer? Yes: _____ No: ______ Do you take medications for your breathing? Yes: _____ No: _____ If yes, please list:

____

10. Do you have any hearing or vision impairments? Yes: ______ No: ______

11. Have you ever had an aneurysm anywhere in your body? Yes: ______ No: ______ If yes, please explain: ______
Has it been repaired? Yes: ______ No: ______

12. Are you diabetic? Yes: ______ No: ______ If yes, did you check your blood sugar today? Reading: ______

13. Males: Do you have a history of prostate problems? Yes: ______ No: ______

14. Do you have glaucoma? Yes: ______ No: ______

15. Females: Could you be pregnant? Yes: ______ No: ______
Date of your last menstrual period: ______

16. Females: Are you currently breast feeding? Yes: ______ No: ______

17. Females: Have you ever had breast surgery? Yes: ______ No: ______

18. Are you able to hold your left arm above your head? Yes: ______ No: ______

19. Are you claustrophobic? Yes: ______ No: ______

20. Are you scheduled for blood draw in the lab today? Yes: ______ No: ______