



Coronary CT Angiography Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Sex: Male _____ Female _____ Age: _____

Height: _____ Weight: _____

Do You Have Any of the Following (check all that apply):

Severe allergies or previous allergic reaction causing respiratory difficulty

Irregular Heartbeat/Arrhythmia

Pace Maker

Chest Pain

Describe _____

Asthma

History of Prior Heart Surgery or Cardiac Catheterization

Dates _____

Family History of Heart Disease

Mother _____ Father _____ Brother(s) _____

Sister(s) _____ Aunt _____ Uncle _____

Grandparent(s) _____

High Cholesterol

Smoking History

Diabetes

Obesity

Hypertension/High Blood Pressure