

Patient Name: _____

DOB: _____

Risks

Tobacco: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Type of Tobacco: _____ Year Quit: _____ Packs/Day: _____ Years Smoked: _____	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cholesterol/Dyslipidemia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Family History of Premature Coronary Artery disease: (Male under 45 or Female under 55) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Adopted (No family history known)	Peripheral Vascular Disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Social History

Family: Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Life partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	Children: <input type="checkbox"/> Yes <input type="checkbox"/> No __ son(s) __ daughter(s) __ total
Life Style: Type of diet <input type="checkbox"/> Regular <input type="checkbox"/> Low fat, low cholesterol <input type="checkbox"/> Low salt <input type="checkbox"/> Diabetic <input type="checkbox"/> Renal <input type="checkbox"/> No added salt <input type="checkbox"/> Weight loss <input type="checkbox"/> Low carb <input type="checkbox"/> Vegetarian	Exercise: <input type="checkbox"/> Sedentary <input type="checkbox"/> Occasional <input type="checkbox"/> Regular <input type="checkbox"/> Active lifestyle <input type="checkbox"/> Physically unable to exercise
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Year Quit: _____ <input type="checkbox"/> Rarely use <input type="checkbox"/> Frequently use <input type="checkbox"/> Occasional use <input type="checkbox"/> Social <input type="checkbox"/> Daily use	Caffeine: <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Illicit Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former
Advanced Directives: <input type="checkbox"/> None <input type="checkbox"/> DNR <input type="checkbox"/> HC Proxy <input type="checkbox"/> Living Will	Personal: Primary Language _____ Secondary Language _____
<input type="checkbox"/> Agree To Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Disabled <input type="checkbox"/> Retired

Are you allergic to any medications? Yes No **List those medications** _____

Are you allergic to X-ray dye? Yes No **Other Allergies?** _____