



Name _____	Date _____
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	YES	NO
Calcium Score		
1. Have you ever had?		
1. A heart attack	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>
3. Balloon Surgery, PTCA, or a stent	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart valve surgery	<input type="checkbox"/>	<input type="checkbox"/>
5. A pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
6. A stroke	<input type="checkbox"/>	<input type="checkbox"/>
7. Hypertension (High Blood Pressure)	<input type="checkbox"/>	<input type="checkbox"/>
8. Angina (Chest Pain)	<input type="checkbox"/>	<input type="checkbox"/>
9. Cardiac Arrhythmia (Irregular Heart Beat)	<input type="checkbox"/>	<input type="checkbox"/>
10. A family history of heart attacks or strokes? Who?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a past smoking history?	<input type="checkbox"/>	<input type="checkbox"/>
4. Females only: Is there any possibility that you might be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
5. A. Have you ever had any previous CT Scan or X-Ray test using contrast/dye?	<input type="checkbox"/>	<input type="checkbox"/>
B. If yes, Have you ever had any previous reaction to the contrast/dye?	<input type="checkbox"/>	<input type="checkbox"/>
C. If yes, what was the reaction?		
6. A. Are you diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
B. If yes, do you take Glucophage (Metformin), Janumet, Avandamet, Glucovance, or Metaglip?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a history of renal or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
BUN: _____ Creatinine: _____ Date Drawn: _____		
8. Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a history of allergies?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you now have or have you ever had the disease Multiple Myeloma?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have Sickle Cell Anemia?	<input type="checkbox"/>	<input type="checkbox"/>

Consent for Diagnostic Testing with Contrast

The test that your doctor has ordered for you today requires the injection through an I.V. of "contrast media" (x-ray dye). The purpose is to help get very clear pictures of your blood vessels.

Contrast media contains iodine and in a few patients may cause a warm feeling or mild, brief nausea, or a temporary rash.

RARELY, a patient may be so sensitive to the contrast that they develop a severe or life-threatening reaction. The medical staff who will perform your scan are trained to recognize and treat any reaction you might have making this test as safe as possible.

Your test will be read by a board certified cardiologist. Further, a board certified radiologist will review the test for any abnormalities not seen in the heart or blood vessels. For the purpose of helping with medical progress, we ask that you allow your results be used if needed in research. If it is used, your name and identifying information will be removed.

If you have any questions, please ask the tech before your test.

I have read and understand the above information and hereby consent to proceed with the test.

Signature of patient or guardian: _____ Date: _____

Signature of witness: _____ Date: _____

FOR OFFICE USE ONLY

Medications Given:	
Diagnostic Procedure Performed:	
Type and Volume of Contrast used:	
Lot #	Expiration Date: