GUILFORD RADIOLOGY
1591 Boston Post Rd., Guilford, CT 06437

CT Scan Questionnaire – Calcium Scoring

Today's Date: _____ MR#: _____

NAME: _____

Date of Birth: _____ Sex: M F

Referring Physician: _____

Do you have a *Family History* of:

- Coronary Artery Disease Y N
- Heart Attack Y N
- Which Members? _____
- Approximate Age of Event(s) _____

Do *YOU* have:

- High Cholesterol Y N
- Do you take medication for High Cholesterol Y N
- Diabetes Y N

Do you smoke? Y N How much? _____

Do you know your blood pressure? _____

Do you take any blood pressure medication? If so, what medication do you take?
_____

Your approximate weight: _____ height:_____

Is there any chance of pregnancy? Y N
Date of last menstrual period _____

Do you exercise regularly? Y N
If yes, please explain your level of workout: _____

Technologist: _____ Date screened:_____