Entira FAMILY CLINICS
Where generations thrive

Stress Echo
Patient Information Sheet

Today's Date: _____

Name: _____ Date of Birth: _____

Last 4 digits of your social security number: _____ (for patient identification purposes)

Height: _____ Weight: _____ Phone number: _____

Primary physician: _____ Clinic location: _____

Reason for today's test: _____

Are you currently having symptoms? Yes / No

If yes, please describe: _____

Are you scheduled to see a cardiologist? Yes / No If yes, what is the appointment date: _____

Yes / No Current smoker
Yes / No Previous smoker (quit more than 6 months ago)
Yes / No Family history of coronary artery disease

Personal Medical History

Yes / No High cholesterol
Yes / No High blood pressure
Yes / No Asthma If yes, do you use an inhaler Yes / No
Yes / No Diabetes If yes, do you take insulin / oral agents Yes / No
Yes / No Peripheral vascular disease
Yes / No Heart attack Date: _____
Yes / No Coronary angioplasty/stent Date: _____
Yes / No Coronary artery bypass surgery Date: _____
Yes / No Heart valve surgery Date: _____
If yes, what valve Mitral / Aortic Tissue / Mechanical
Yes / No Pacemaker
Yes / No Heart defibrillator

Current Medications (stress test / stress echo patients only)

_____ _____ _____

_____ _____ _____