MNAP Medical Solutions

9908 East Roosevelt Boulevard, Philadelphia, PA 19115
Phone 215-464-3300 | Fax 215-464-5403 | www.mnap.com

Cardiovascular CTA Evaluation

Name	Date of Birth

Email

Describe your symptoms

Check the applicable symptoms:

☐ Neck Pain	☐ Shoulder Pain	○ L	○ R
☐ Upper Back Pain	☐ Arm Pain	○ L	○ R
☐ Mid Back Pain	☐ Hand/Finger Pain	○ L	○ R
☐ Low Back Pain	☐ Hip Pain	○ L	○ R
☐ Right Flank (Side) Pain	☐ Leg Pain	○ L	○ R
☐ Left Flank (Side) Pain	☐ Foot/ Toe Pain	○ L	○ R
☐ Chest Pain	☐ Arm Numbness	○ L	○ R
☐ Abdominal Pain	☐ Finger Numbness	○ L	○ R
☐ Pelvic/Groin Pain	☐ Leg Numbness	○ L	○ R

If the CT exam is of the head, check the applicable symptoms:

☐ Headaches	☐ Aphasia (Any Speech Disorder)		
☐ Seizure	☐ Loss of Sence of Smell		
☐ Syncope (Fainting)	☐ Difficulty Swallowing		
☐ Loss of Balance	☐ Body Numbness/Weakness	○ L	○ R
☐ Memory Loss	☐ Facial Numbness/Weakness	○ L	○ R
☐ Confusion	☐ Hearing Loss	○ L	○ R
☐ Ataxia (Loss of Coordination)	☐ Tinnitus		
☐ Dizziness	☐ Blurred/Double Vision	○ L	○ R
☐ Slurred Speech	☐ Blurred/Double Vision	○ L	○ R

Continued on Next Page →

1. **Have you had any history of stroke?**
   ☐ Yes ☐ No
   Date

2. **Have you had any history of cancer?**
   ☐ Yes ☐ No
   Type

3. **Have you had any history of trauma?**
   ☐ Yes ☐ No
   Date

4. **When was the last time you had something to eat or drink?**

5. **Any chance of pregnancy?**
   ☐ Yes ☐ No ☐ N/A

6. **Date of your last menstrual period?**

7. **Are you currently breast feeding?**
   ☐ Yes ☐ No ☐ N/A

8. **Please list any surgeries you have had:**

Please tell us whether or not you have a history of any of the following medical conditions:

Asthma	☐ Yes	☐ No	Comments
Cardiac Arrhythmias	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Peripheral Vascular Diseases	☐ Yes	☐ No	
Kidney Disorder	☐ Yes	☐ No	

Have you undergone any of the following medical procedures?

Angioplasty	☐ Yes	☐ No	Comments
Bypass Surgery	☐ Yes	☐ No	
Coronary Calcium Scoring	☐ Yes	☐ No	
Coronary Stent	☐ Yes	☐ No	
Pacemaker	☐ Yes	☐ No	

Have you ever had the following?

Heart Attack	☐ Yes	☐ No	Comments
Elevated C-Reactive Protein	☐ Yes	☐ No	

Do you have a family history of coronary artery disease?	☐ Yes	☐ No	☐ Unknown
Have you ever taken beta blocker medication?	☐ Yes	☐ No	☐ Unknown
Are you unable to tolerate beta blocker medication?	☐ Yes	☐ No	☐ Unknown

Do you smoke? ☐ Yes ☐ No If yes, how much? For how long?

Continued on Next Page →

Please answer the following questions for contrast injections only

1. **Please list below or bring a list of all medications you are taking**

2. **Do you have an allergy to shellfish?**
   ☐ Yes ☐ No

3. **Any allergies you may have:**

4. **Are you a diabetic?**
   ☐ Yes ☐ No If yes, please list the type of medication you are taking for the diabetes

5. **Do you have heart disease?**
   ☐ Yes ☐ No

6. **Do you have kidney disease?**
   ☐ Yes ☐ No

7. **Do you have asthma?**
   ☐ Yes ☐ No

8. **Have you had an x-ray or CT that required an iodine contrast injection into a vein?**
   ☐ Yes ☐ No
   If yes, did you have any reaction to this injection?
   ☐ Yes ☐ No

Patient Signature	**Date**
Technologist Signature	**Date**