Hunterdon Healthcare
Your full circle of care.

Department of Nuclear Medicine – Cardiac Checklist

Welcome to the Nuclear Medicine department of Hunterdon Medical Center.

Please answer all of the following questions. This information will assist us in learning your medical history. The technologist performing your study can assist you with any questions or concerns you have with your test.

Patient Name _____ Date of Birth _____

Height_____ Weight_____

1. Reason for test? _____

2. Do you have any allergies to any medications? YES NO
   If YES, please list all medications:
   _____
   _____

3. Do you currently take any medication? YES NO
   If YES, please list all medications and the last time you took them:
   _____
   _____
   _____

4. Do you have high blood pressure? YES NO

5. Do you have heart disease? YES NO
   If **YES,** have you had any of the following?
   - Heart Attack? YES NO
   - Angioplasty or Stents? YES NO
   - Bypass Surgery? YES NO

6. Do you have Asthma? YES NO

7. Do you have Diabetes? YES NO

8. Have you had caffeine or decaffeinated products within the last 24 hours?
   (i.e. Soda, Tea, Coffee, Chocolate, Excedrin, or energy drinks.) YES NO
   If **YES,** please list
   _____
   _____

9. Have you had anything to eat or drink in the last **4 hours**? YES NO

10. For Female patients ***ONLY:***
    - Any possibility you may be pregnant? YES NO
    - Are you currently breast-feeding? YES NO