CLARKSVILLE
IMAGING
CENTER
OPEN MRI • CT • ULTRASOUND

Cardiac Scoring Screening Questionnaire

To learn more about our patients and to better evaluate this screening, please answer the following questions.

Name: _____

Age: _____

	Yes	No
Do you have a family history of heart disease?	____	____
Do you smoke, or are you exposed to second-hand smoke?	____	____
Have you ever been diagnosed with high cholesterol?	____	____
Have you ever been diagnosed with high blood pressure or hypertension?	____	____
Do you have an inactive lifestyle?	____	____
Do you consider yourself overweight?	____	____
Do you have uncomfortable chest pain, fullness, pressure or squeezing?	____	____
Do you ever feel pain spreading to the shoulders neck or arms?	____	____
Have you had chest discomfort with lightheadedness, fainting, sweating, nausea or shortness of breath?	____	____
Have you had any sudden numbness or weakness of face, arm or leg, especially on one side?	____	____
Have you had any sudden confusion, or trouble with speaking, understanding, or walking, balance or sight?	____	____
Have you had any sudden severe, unexplained headaches?	____	____

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