ACA
ACADEMIC CARDIOLOGY ASSOCIATES, P.C.

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# STRESS TEST QUESTIONNAIRE

Name: _____ Age: _____ Height:_____ Weight:_____

Birthdate:_____

Family Doctor(s) name: _____

Cardiologist:_____

1. Why does your doctor want you to have this stress test? _____
2. Have you had a stress test before? No: ____ Yes: ____ Date: _____
   Where was test done:

_____

3. If you had a stress test before, why was the test stopped? (Please circle all that apply.)
   a) Fatigue b) Chest pain c) Irregular heart beat
   d) Dizziness e) Shortness of breath f) Leg cramps
4. Have you had recent problems with chest pain or discomfort?
   No: _____ (If answered "No" please go on to question #11.)
   Yes:_____ (If answered "Yes" please circle all that apply in #5 through #11.)
5. The pain or discomfort feels like:
   a) Pressure b) Ache c) Heaviness d) Squeezing
   e) Burning f) Tightness g) Sharp h) Stabbing
   j) Other _____
6. The pain or discomfort is located?
   a) Middle of my chest b) Across my chest c) Down my right arm
   d) Down my left arm e) In my stomach f) In my neck or throat
7. The pain or discomfort comes on:
   a) With physical exertion b) At rest c) With stress
   d) With eating e) Not sure
8. The pain or discomfort lasts:
   a) Seconds b) 5-15 minutes c) Hours

9. The pain or discomfort goes away with:

a) Rest b) Antacids c) Nitroglycerin

d) continued activity e) Not sure.

10. The pain or discomfort has been a problem for: (Fill in one of the blanks.)

a) _____ weeks b) _____ months c) _____ years

11. Have you ever had a heart attack? No_____ Yes_____ Date:

_____

12. Have you ever had catheterization? No_____ Yes_____ Date:

_____

13. Have you ever had coronary artery angioplasty (balloon catheter) or stent placement?

No_____ Yes_____ Date: _____

14. Have you ever had heart surgery? (Circle all that apply.) No_____ Yes_____

a) Coronary artery bypass Date:_____

b) Heart valve surgery Date:_____

c) Other Date:_____

15. Have you had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Swelling in the legs | Yes | No | Coughing Blood | Yes | No |
| High Blood Pressure | Yes | No | High Cholesterol | Yes | No |
| Congestive heart failure | Yes | No | Cigarette Smoking | Yes | No |
| Severe leg cramps with walking | Yes | No | Diabetes | Yes | No |
| Emphysema | Yes | No | Irregular heart beats | Yes | No |
| Rheumatic fever | Yes | No | Fainting spells | Yes | No |
| Stroke | Yes | No | Unable to sleep lying flat | Yes | No |

16. Have any of your family members had a heart attack? _____ No _____ Yes

Please list relationship to you

_____

17. Are there any limits on your ability to walk on a treadmill?

_____ No _____ Yes Please describe:

_____

18. List any

allergies:_____

19. List your current medications, dosages, and when you last took them:

_____

_____