ACADEMIC CARDIOLOGY ASSOCIATES

Martin F. McGough, M.D., F.A.C.C., F.A.S.E. John S. Heath, M.D., F.A.C.C. Phillip L. Kraft, M.D., F.A.C.C.,
John A. Sallach, M.D. F.A.C.C., F.A.S.E. Jason Crile, M.D. Courtney Nason AGPCNP-BC Cindy Engle, AGPCNP-BC

1701 South Blvd East Suite 390, Rochester Hills, MI. 48307 (248) 293-0055, Fax (248) 293-334

STRESS TEST QUESTIONNAIRE

Name: _____

Date of Birth/Age _____ Height: _____ Weight: _____

Family Physician(s) Name: _____ Cardiologist: _____

1 Why does your physician 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 check all that apply)

Fatigue ☐ Chest pain ☐ Irregular heart beat ☐ Dizziness ☐ Shortness of breath ☐ Leg cramps ☐

4 Have you had recent problems with chest pain or discomfort?

No: _____ (If answered "No", please go to question #11.)

Yes: _____ (If answered "Yes" please check all that apply in #5 through #11.)

5. The pain or discomfort feels like:

Pressure ☐ Ache ☐ Heaviness ☐ Squeezing ☐ Burning ☐ Tightness ☐ Sharp ☐ Stabbing ☐

6. The pain or discomfort is located?

Middle of my chest ☐ Across my chest ☐ Down my right arm ☐ Down my left arm ☐

In my stomach ☐ In my neck or throat ☐

7. The pain or discomfort comes on:

With exertion ☐ At rest ☐ With stress ☐ With eating ☐ Not sure ☐

8. The pain or discomfort lasts:

Seconds ☐ 5-15 minutes ☐ Hours ☐

9. The pain or discomfort goes away with:

   Rest ☐ Antacids ☐ Nitroglycerin ☐ Continued Activity ☐ Not sure ☐

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

    _____ weeks _____ months _____ years

11. Have you ever had a heart attack? No _____ Yes _____ Date: _____

12. Have you every had a catherization? No _____ Yes _____ Date: _____

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

    No _____ Yes _____ Date: _____

14. Have you ever had heart surgery? (Check all that apply) No _____ Yes _____

    Coronary artery bypass ☐ Date: _____

    Heart Valve Surgery ☐ Date: _____

    Other ☐ Date: _____

15. Have you had any of the following?

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

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: _____

    _____

    _____

    _____

    _____