

EVALUATION OF CORONARY ARTERY DISEASE

Client's Name _____

If your client has had a stress ECG, please list the date(s) _____

1. Was the stress ECG...
 normal abnormal borderline

2. Was any other testing completed...

	normal	abnormal
thallium stress ECG	<input type="checkbox"/>	<input type="checkbox"/>
stress <u>echocardiogram</u>	<input type="checkbox"/>	<input type="checkbox"/>
coronary angiogram	<input type="checkbox"/>	<input type="checkbox"/>

3. Please check if your client has had any of the following:

<input type="checkbox"/> history of chest pain	<input type="checkbox"/> diabetes
<input type="checkbox"/> elevated cholesterol	<input type="checkbox"/> family history of heart disease
<input type="checkbox"/> overweight	<input type="checkbox"/> high blood pressure

4. Is your client on any medications?
 yes, please give details: _____
 no

5. Has your client smoked cigarettes in the last 12 months? yes no

