



ACADEMIC CARDIOLOGY ASSOCIATES, P. C.

Martin F. McGough, M.D., F.A.C.C., F.A.S.E.
John H. Cieszkowski, M.D., F.A.C.C.

John S. Heath II, M.D., F.A.C.C.
Phillip L. Kraft, M.D., F.A.C.C.

1701 South Blvd East Suite 390, Rochester Hills, MI 48307 (248) 293-0055 Fax (248) 293-3348

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:
