BLUE STAR IMAGING | BOERNE

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CALCIUM SCORE SCREENING FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female Weight: _____ Height: _____

Ethnic Background: ☐White ☐Black ☐Asian ☐Hispanic ☐Other: _____

What symptoms are you experiencing? _____

Referring Physician: _____

ARE YOU: DIABETIC: ☐ YES ☐ NO A SMOKER: ☐ YES ☐ NO CLAUSTROPHOBIC: ☐ YES ☐NO

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

Do you have high blood pressure (hypertension)?	☐**Yes** ☐**No**
Do you have high cholesterol?	☐**Yes** ☐**No**
Do you have heart disease?	☐**Yes** ☐**No**
Do you have a family history of heart disease?	☐**Yes** ☐**No**

FEMALE PATIENTS ONLY

☐ Yes	☐ No	Is there a chance that you are pregnant?
☐ Yes	☐ No	Are you currently pregnant?
☐ Yes	☐ No	Have you had a hysterectomy or tubal ligation?
☐ Yes	☐ No	Are you currently nursing?

FORM OF BIRTH CONTROL

☐ Abstinence	☐ Condom
☐ Birth Control Pills/Patch	☐ IUD
☐ Diaphragm	☐ Menopause
☐ Other	☐ None

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____