Century Pre-Screening Questions

Referral Treadmill Y N

Gender M F

Patient Name: _____

Telephone Number: C _____ H _____ W _____

Email Address: _____

Mailing Address: _____

D.O.B. _____ Age: _____

Weight: _____ Height: _____ BMI(Must be ≤ 35) _____

Do you have heart disease? (Blocked arteries in heart, angioplasty, stent, bypass, or a heart attack) Y N

Do you have Atherosclerotic Carotid artery disease (ACAD) or Atherosclerotic peripheral vascular disease (APVD)? (Blocked arteries going to the neck or legs or a stroke) Y N

Do you have Diabetes? Meds.? Y N

Do you have high blood pressure? Medication? Y N

Do you have high cholesterol? Medication? Y N

What are your LDL and HDL? Latest lab date?_____ LDL _____ Y N

HDL _____ Y N

Current or recent cigarette smoking within the last 12 months? Y N

Do you have relative with Heart Disease? (parents and siblings) Y N

If yes, who and how old were they when diagnosed? (parents Must be ≤ 60) _____

Do you have any symptoms of chest pain? Y N

Do you have a cardiologist or PCP? Dr. _____ Y N

Have you had SPECT/Nuclear Stress Test? If so, when? _____ Y N
(Must be within 2 weeks or > 1 yr)

Recent stroke or heart attack within the last 4 weeks? Y N

Recent heart surgery/procedures within the last 6 months? Y N

Do you have kidney disease, liver disease, or cancer? Y N

Are you able to walk on a treadmill? Y N

Are you participating in any other research within the last 30 days? Y N

Screening date: _____ Time started: _____ Time finished: _____

Please fax completed form to Century Health Study at **713-704-2695**

Century Study Hotline **713-500-5200** **www.CENTURYHEALTHSTUDY.ORG**

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