NASSAU CARDIAC DIAGNOSTICS
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Please complete the following prior to your test:

NAME: _____ TEST DATE: _____

AGE: _____ Height: ____ft. ____in. Weight: _____lbs.

NAME/ADDRESS OF REFERRING PHYSICIAN, or other physicians to whom we should send your reports:

_____

_____

Please list your medications and time of last dose:

Medication	Time of last dose

Please check if any of the following applies to you:

High blood pressure	Prior heart attack
Diabetes	Prior angioplasty/stent
High cholesterol	Heart trouble in the family
Smoking now	Chest pain
Ever smoked?	Allergy to medication
Asthma	Other allergies
Other breathing problems	Heart murmur