[Standard Header]

Patient Name: {clmt_full_name}

PLEASE COMPLETE AND RETURN BY {mer_return_date}

CARDIAC QUESTIONNAIRE for MEDICAL SOURCE

1) Diagnosis: _____ Date of diagnosis: _____

2) Date and findings of most recent exam: _____

_____

3) Has your patient had an exercise test? ☐ Yes ☐ No

If no, why not? _____

4) Would undergoing exercise testing pose significant risk for your patient? ☐ Yes ☐ No

5) If the patient has chest pain, is it related to a cardiac condition? ☐ Yes ☐ No

If no, what non-cardiac condition is causing chest pain? _____

6) Has the patient experienced cyanosis at rest? ☐ Yes ☐ No On exertion? ☐ Yes ☐ No

7) Describe any evidence of neurological complications (for example, ataxia, paralysis, aphasia).

_____

_____

8) Is there evidence of end-organ damage as a result of a cardiac condition (for example, kidney failure, retinopathy)? ☐ Yes ☐ No

If yes, describe. _____

_____

9) Have the symptoms persisted despite treatment? If so, please describe.

_____

10) Describe any restrictions to work-related activities, if not previously provided (for example, walking, lifting, carrying, environmental restrictions).

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NOTE: Please submit copies of tracings, testing, and laboratory results, if you have not provided them previously.

_____	_____	_____
Medical Source Signature	Date	Phone Number
_____		_____
Printed Name		Title