Health Village Imaging

A Member of the Hackensack Meridian Health Network

PATIENT NAME: ___________________________________**DATE OF BIRTH**: ____________________

Referring Physician: ________________________________

Height ___________ Weight ___________

Do you have a family history of diabetes?	**Yes**	**No**	
Do you have high cholesterol?	**Yes**	**No**	
If yes to high cholesterol, are you on medication?	__________________________		
Do you have high blood pressure?	**Yes**	**No**	
If yes to high blood pressure, are you on medication?	__________________________		
Are you a past or present smoker?	**Past**	**Present**	**No**
Do you have an active or inactive lifestyle?	**Active**	**Inactive**	

Please give date and type of any **HEART** surgery or procedure:

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Any possibility of pregnancy? **Yes** **No** **Don't know**

First date of last menstrual period? ________________________

Signing below indicates that you have read and understand this form and have completed it to the best of your ability.

Patient or Legal Representative Signature ____

Technologist Signature____Date______________