OREGON IMAGING CENTERS

CT Heart – Calcium Scoring

Name: _____ Date: _____

Height: _____ Weight: _____

HEART AND STROKE PREVENTION SELF-ASSESSMENT

The following factors may increase your risk. Check all boxes that apply to you.

Your AGE and SEX may increase your risk if...

- ❑ You are a man over 45 years old.
- ❑ You are a woman over 50 years old, **OR** you have passed menopause, **OR** you have had your ovaries remove.

Your FAMILY HISTORY may increase your risk if...

- ❑ Your father or brother had a heart attack before age 55 **OR** your mother or sister had one before age 65.
- ❑ You have a close blood relative who had a stroke.

Your BLOOD PRESSURE may increase your risk if...

- ❑ Your blood pressure is 140/90 mm Hg or higher, OR you've been told that your blood pressure is too high.
- ❑ You don't know what your blood pressure is.

Tobacco SMOKE increases your risk if…

- ❑ You smoke, or live or work with people who smoke every day.

Your total CHOLESTEROL and HDL cholesterol levels may increase your risk if...

- ❑ Your total cholesterol level is 240 mg/dL or higher.
- ❑ Your HDL ("good") cholesterol level is less than 40 mg/dL.
- ❑ You don't know your total cholesterol or HDL levels.

PHYSICAL INACTIVITY may increase your risk if...

- ❑ You get less than a total of 30 minutes of physical activity on most days.

Excess BODY WEIGHT may increase your risk if...

- ❑ You are 20 pounds or more overweight for your height and build.

DIABETES increases your risk if...

- ❑ You have diabetes (a fasting blood sugar of 126 mg/dL or higher), **OR** you need medicine to control your blood sugar.

Your MEDICAL HISTORY may increase your risk if...

- ❑ You have coronary heart disease, atrial fibrillation or other heart condition(s), OR you've had a heart attack.
- ❑ You've been told that you have carotid artery disease, **OR** you've had a stroke or TIA (transient ischemic attack), **OR** you have a disease of the leg arteries, a high red blood cell count or sickle cell anemia.

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REQUEST FOR ACCESS TO OR COPIES OF PROTECTED HEALTH INFORMATION

Individual's Name	LAST	FIRST	MIDDLE
Home Address			
Home Phone		DATE OF BIRTH	

1. I request that Oregon Imaging Centers provide me with [please check all boxes that apply]:

   ❑ **access to** ❑ **my own copy** of the requested information checked below:

   ❑ for the dates from (_ _/_ _/_ _) to (_ _/ _ _/_ _)

   ❑ and for services provided at the following Oregon Imaging Centers facility or clinic _____

2. This request is for:

   ❑ Transcribed reports, including clinical and ancillary reports

   ❑ Clinical chart notes, may include nursing records, graphic charts and progress notes.

   ❑ Billing statements (Fax to Tracy Holt at PerSe (559) 455-4004)

   ❑ Other (specify): _____

3. I understand that Oregon Imaging Centers or a copy service retained by Oregon Imaging Centers may charge me according to the current Fee Schedule to complete my request, as well as any applicable mailing fees.

_____ _____
Signature of Patient Date

_____ _____
Signature of Personal Representative Relationship to Patient

_____
Identification

Please route this completed form to OIC's Health Records Department.

**** You will receive a paper copy of your report in the mail ****