MULTICARE ASSOCIATES

**Blaine Medical Center**
11855 Ulysses Street NE
Blaine, Minnesota 55434

**Fridley Medical Center**
7675 Madison Street NE
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**Roseville Medical Center**
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# Treadmill Exercise Pre-test Questionnaire

Name ________________________________________________ Age ____________

Today's Date ________________________________ Date of Birth ________________

Medication ________________________________

To your knowledge, why is this test being done?________________________________

________________________________________________________________

Who ordered the test? ________________________________________________

Please check if your immediate family has a history of:

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Coronary Bypass surgery

PATIENT PAST MEDICAL HISTORY Check if you have had any of the following and when:

- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Coronary Bypass
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity

LIFESTYLE

- ☐ Stress: What?
- ☐ Smoking: How much?
- ☐ Alcohol: How much?
- ☐ Exercise: How often?

Patient Instructions for Treadmill EKG

1. No smoking after midnight and before the test.
2. Wear walking shoes, preferably tennis shoes.
3. Wear light clothing.
4. No food two hours before the test.
5. Take your usual medications on schedule EXCEPT the medications on the list provided.
6. If you have any questions on the above instructions, please call 763.785.4500 and discuss with an internal medicine nurse.

**WE REQUIRE 24-HOUR ADVANCE NOTICE IF YOU ARE UNABLE TO KEEP THIS APPOINTMENT.**

**THANK YOU!**

**Please do NOT take the medications listed below for a Stress Test or Nuclear Cardio Procedure.**

## HOLD 24 Hours prior to test

### Beta Blockers

Acebutol
Atenolol
Betaxolol
Bisoprolol
Blocadren
Carteolol
Coreg
Corgard
Inderal
Kelone
Labelatol
Lopressor
Metoprolol
Nadolol
Pindolol
Propranolol
Secral
Sotalol
Tenormin
Timobl
Toprol
Toprol XL
Visken
Zebeta
Ziac

### Calcium Channel Blockers

Adalat
Calan
Calan SR
Cardizem CD
Dilacor XL
Diltiazem
Isoptin
Nifedipine
Tiazac
Verapamil

Digoxin
Lanoxin

### INSULIN

Hold regular insulin (Humalog)
Take 1/2 long acting insulin

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## HOLD 12 hours prior to test

Nitrates
Deponit
Dilatrate
Imdur
Isosorbide Mononitrate
Isordil
Minitran
Monoket
Nitro-bid
Nicocine
Nitro-derm
Notrodisc
Nitro-dur
Nitrogard
Nitroglycerin
Nitroglyn
Nitrol
Nitran
Nitrosat
Sorbitrate
Transderm-nitro

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## HOLD 36 hours prior to test

Aggrenox
Dipyridamole
Ulralentl

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## HOLD 48 hours prior to test

Theophylline
Aminophylline
Choledryl
Constant-T
Elixophylline
Quiborn-T
Oxtriphylline
Respbid
Slo-bid
Slo-phyllin
Sustaire
Theo-24
Theobid
Theochron
Theoclear
Theo-dur
Theolair
Theo-sav
Theospan
Theovent
T-Phyl
Uniphyl

# Electrocardiographic Exercise Test

Date: ___________________

Time: ___________________

The treadmill exercise test is being conducted for the purpose of making a diagnosis in certain cases of chest pain, or to determine exercise tolerance and heart rate and blood pressure levels with exercise, or to provide you with an exercise prescription.

There are certain risks associated with this test including risk of heart attack or sudden cardiac death. This risk is minimal and your doctor will terminate the test if there are any adverse indications.

Please tell the doctor if you have any symptoms of chest pain, shortness of breath, dizziness, or anything that should make you want to stop.

I, the undersigned, a patient at Fridley Medical Center, hereby authorize Dr. ___________________ (and whoever is designated to assist) to administer such treatment as is necessary to perform the Electrocardiographic Exercise Test (Bruce Multistage Treadmill Test) and such additional procedures as are considered therapeutically necessary on the basis of findings during the course of said procedure.

I hereby certify that I have read and fully understand the able authorization, the reasons why the above named procedure is considered necessary, its advantage and possible complication, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. ___________________. I also certify that no guarantee of assurance has been made as to the results that may be obtained.

Signature _________________________________________________ Relationship ______________________________
(patient or nearest relative)

Witness: ________________________________________

________________________________________

**Note: Authorization must be signed by the patient or by nearest relative in the case of a minor or when a patient is physically or mentally incompetent.**