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

**HOLD 36 hours prior to test**
- Aggrenox
- Dipyridamole
- Ulratentl

**HOLD 48 hours prior to test**
- Theophylline
- Aminophylline
- Choledryl
- Constant-T
- Elixophylline
- Quiborn-T
- Oxt Priphylline
- Respbid
- Slo-bid
- Slo-phyllin
- Sustaire
- Theo-24
- Theobid
- Theochron
- Theoclear
- Theo-dur
- Theolair
- Theo-sav
- Theospan
- Theovent
- T-Phyl
- Uniphyl

- Nitran
- Nitrosat
- Sorbitrate
- Transderm-nitro
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.