McLaren
CARO REGION

STRESS TESTING

Patient Name _____ Date _____ MR # _____

DOB_____ Age _____ M F Height _____ Weight _____

Referring Physician _____ Supervising Physician _____

Diagnosis _____

PAST HISTORY

Heart Disease ( )
CABG ( )
Stent(s) ( )
Fm Hx Heart Disease ( )
High Blood Pressure ( )
Heart Palpitations ( )
Lung Disease ( )
Diabetes ( )

PRESENT SYMPTOMS

Chest Discomfort ( )
Shortness of Breath ( )
Smoker ( )
Back, Shoulder, Arm Pain ( )
Indigestion ( )
Other _____

ALLERGIES: _____

MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____ _____

Stress Type: GXT Treadmill _____ Nuclear _____ ECHO _____

Dobutamine Dose _____ Lexiscan Dose _____

MISC. Med. _____

Max HR _____ Target HR _____

Stage	BP	HR	SAT	Comments
Rest				
Recovery				

Time of Termination _____ Reason for stopping test _____

Cardio Tech Signature: _____

FORM: CP 5
REV: 2-5-19