Susquehanna Health
Heart & Vascular Institute

In affiliation with

Cleveland Clinic
Heart and Vascular Institute

Stress Echo Test

Listed below are the instructions for your Stress Echo Test:

A. 24 hours before your test...

If you have any questions about your medications, please check with your physician.
Do not eat anything two (2) hours before your test. (You may drink water)

B. On the day of your test...

Please bring:

- The enclosed completed questionnaire.
- A list of medications that you are currently taking.
- Any inhalers that you may use.
- Reading glasses, if needed.
- Your cane, walker, or wheelchair if normally used.

Please wear:

- Comfortable clothing and shoes (sneakers or tied shoes).
- Perfumes and colognes sparingly.

Please allow one hour to complete your stress echo test.

After your test, you will be able to drive home.

C. DIRECTIONS TO THE DEPARTMENT

Please park in East or West parking off of Rural Avenue. Valet parking services are available at the West Entrance.

If you do not need valet services, it is best to use the Rural Avenue entrance at the blue canopy. Just inside the Rural Avenue entrance are the B elevators, take these down to the 2nd floor. Turn left off the elevator and the testing center is straight ahead and slightly to the left.

Stress Echo Test

If you have any questions, please do not hesitate to call us at 570-321-2700, and ask to speak with a stress lab nurse.

Please give 24 hours notice if you cannot keep your appointment by calling 570-321-2700.

Thank you for choosing Susquehanna Health. We look forward to serving you!

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Stress Test Questionnaire

INSTRUCTIONS: PLEASE CIRCLE NO/YES AND ALSO CIRCLE CONDITIONS THAT APPLY TO YOU:

Do you have any allergies? NO / YES – Please list them:
Have you ever had a heart attack? NO / YES – When? How many?
Do you have a family history for heart disease? NO / YES – (High Blood Pressure / Heart Attack / Heart Surgery?
Have you ever had coronary balloon angioplasty and/or stent? NO / YES – When?
Have you ever had coronary bypass surgery? NO / YES – When? How many vessels?
Have you had: Chest Pain / Chest discomfort / Chest Pressure / Chest Heaviness / Heartburn / Arm Pain / Neck Pain / Jaw Pain. NO / YES – When? With rest / activity
Have you ever passed out? NO / YES – When?
Have you ever had: Congestive Heart Failure / Fluid in Your Lungs, or Weak Heart? NO / YES When?
Have you ever had shortness of breath? NO / YES – When? With rest / activity?
Do you ever wake up short of breath? NO / YES – When?
Do you have problems lying flat to sleep? NO / YES – How many pillows do you use?
Do you have diabetes? NO / YES
Do you have high cholesterol? NO / YES
Do you smoke? NO / YES Have you ever smoked? NO / YES How much? How many years have you smoked? When did you quit?
Do you have lung problems? NO / YES – Specify: _____ Asthma? NO / YES Emphysema? NO / YES Bronchitis? NO / YES Blood Clots in Lungs? NO / YES
Do you have any problems with rhythm of your heart? NO / YES – Specify: Palpitations / Fast or Racing Heart Beat / Atrial Fibrillation / Skipped Heart Beats / Pacemaker
Do you have any: Heart Valve Problems / Heart Murmur? NO / YES – Specify:
Do you: Get tired easily / Do less and get tired quicker? NO / YES
Have you ever had: Chemotherapy / Or are you about to start? NO / YES – When?
Do you have any other symptoms? NO / YES – Specify:
Patient Signature: DATE:
For Myoview Stress Test:
Bra ON / OFF for scan Breast Prosthesis / Implants: NO / YES Bra Size: