



DELAWARE CARDIOVASCULAR ASSOCIATES

34453 King Street Row
Lewes, DE 19958
302-644-7676

92A Atlantic Avenue
Ocean View, DE 19970
302-537-7676

EXERCISE NUCLEAR STRESS TEST
DOBUTAMINE

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

NAME _____ APPOINTMENT: _____

THIS TEST TAKES APPROXIMATELY 3 TO 4 HOURS

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY REQUIRE US TO RESCHEDULE YOUR TEST

1. **NO CAFFEINE OR DECAF PRODUCTS 24 HOURS PRIOR TO PROCEDURE.**
2. You may eat a light meal 2 ½ hours before your test (i.e. juice, fruit, oatmeal).
3. You may drink water at any time.
4. **NO SMOKING** 2 hours prior to your test.
5. **MEDICATIONS:**
 - A. Stop all erectile dysfunction medications **24 hours** prior to test
 - B. Stop any medication on list attached **48 hours** prior to test. Please bring these medications to take after your test.
6. Wear short sleeves because you will have an IV in your arm. You may bring a light jacket or sweater that is easy to remove if needed. **NO** metal on your top including zippers, pins, or necklaces. Please wear comfortable walking shoes.
7. **FAILURE TO GIVE 24 HOURS NOTICE FOR CANCELLATIONS WILL RESULT IN A \$50 FEE BILLED TO YOU, FOR ADMINISTRATIVE & MEDICATION COSTS INCURRED.**



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DRUGS TO AVOID FOR EXERCISE STRESS TESTING (ARE NOT A REASON TO CANCEL TESTING)

CALCIUM CHANNEL BLOCKERS

ADALAT
AMLODIPINE
CALAN
CALAN SR
CARDENE
CORERA HS
CARDIZEM CD
DILTIAZEM/
DILACOR (XR)
DILTIAZ T
TIAZAC
VERAPAMIL
VERELAN
VERELAN PM
VERAMAPIL SR

NITRATES

NITROGLYCERIN

*NITRO-DUR, NITRSOSTAT
*NITROLINGUAL PUMPSPRAY
* ISOSORBIDE MONONITRATE
*DILATRATE/ISORDIL/SORBITRATE

BETA BLOCKERS

ACEBUTOLOL
ATENOLOL
BETAXOLOL
BISOPROLOL
BLOCADREN
BREVIBLOX
BYSTOLIC
CARDIZEM
CARTEOLOL
CARTROL
CARVEDILOL
COREG
CORGARD
CORZIDE
ESMOLOL
FUMARATE
IMDUR
INDERAL
KERLONE
LABETALOL
LEVATOL
LOPRESSOR
METOPROLOL SUCCANETE/TARTRATE
MONOKET
NADOLOL
NEBIROLOL
NORMODYNE
PENBUTOLOL
PINDOLOL
SECTRAL
TENORETIC
TENORMIN
TIMOLOL
TIMOLIDE
TOPROL XL
TRANDATE
ZEBETA
VISKEN TABS
ZEBETA
ZIAC

Commonly used Drinks and Foods Containing Caffeine

Coffee

Brewed drip coffee	60-180 mg/5 oz cup
Brewed percolated coffee	40-179 mg/5 oz cup
Instant coffee	30-190 mg/5 oz cup
Decaffeinated brewed coffee	2-5mg/5 oz cup
Decaffeinated instant coffee	1-5 mg/5 oz cup

Tea

Brewed commercial tea	20-90 mg/5 oz cup
Brewed imported tea	25-110 mg/5 oz cup
Instant tea	2-20 mg/5 oz cup
Iced tea	67-76 mg/12 oz cup

Cocoa

Chocolate milk

	2-20mg/5 oz cup
	25-110 mg/8 oz cup

Food

Milk chocolate	1-15 mg/1 oz
Dark semisweet chocolate	5-35 mg/1 oz
Bakers chocolate	average 26 mg/1 oz
Chocolate syrup	average 4 mg/1 oz
Chocolate cake	13.8 mg/92 g serving (1/16 of a 9in cake)
Chocolate candy	7.7 mg/1 oz bar
Candy, chocolate covered	2.8 mg/1 oz bar
Chocolate ice cream	4.5 mg/ 2/3 cup
Chocolate pudding, instant	5.5 mg/1/2 cup
Nut fudge brownie	7.7 mg/1 1/4 oz

Soft drinks

Coca-cola	45.0 mg
Cola, decaf	trace-0.18 mg
Dr. Pepper	39.6 mg
Dr. Pepper, sugar free	39.6 mg
Jolt Cola	70.0 mg
Mellow Yellow	54.0 mg
Mountain Dew	54.0 mg
Mr. Pibb	40.5 mg
Pepsi Cola	38.4 mg
Diet Pepsi	36.0 mg
Tab	46.5 mg

Some OVER-THE-COUNTER Drugs that contain Caffeine

Anacin	32 mg
Excedrin	65 mg
No Doz	100 mg

Prescription Meds Containing Caffeine

Cafergot (all forms)	100 mg
Darvon Compound	32.4 mg
Fiorinal	40 mg
Synalgos- DC	30 mg
Wigraine (all forms)	100 mg

Prescription Meds containing THEOPHYLLINE*

Theo-24	Theoclear LA	Theovent Long-Acting
Bronkodyl	Slo-bid Gyrocaps	Sustaire
Theospan-SR	Uniphyll	Theobid Jr. Duracap
Theo-Dur Sprinkle	Theophylline S.R.	Elixophyllin SR
Slo-Phylline Gyrocaps	Constant-T	Quibron-T/SR
Theochron	Theolair-SR	Theobid Duracap
Theo-Dur	Aerolate	Respbid

**See PDR for more complete list.

♥ Delaware Cardiovascular Associates ♥
History & Physical Examination

Patient Name _____ Age _____ DOB _____ Date _____

Family Doctor _____ Referring Doctor _____

1. Indication:
2. Symptoms
3. Previous Cardiac Procedures:

RISK FACTORS

HYPERTENSION
HYPERLIPIDEMIA
SMOKER
FAMILY HISTORY
DIABETES
OTHER _____

Medications: Reviewed attached list

Physical Examination:

Vitals: Pulse _____ BP _____ Wt _____

Cardiovascular Examination: _____

Pulmonary Examination: _____

Labs: Reviewed

BASELINE EKG: _____

Assesment: CAD evaluation / follow up by stress test

Recommendation:

1. No contraindication for planned stress test from a cardiovascular point of view.
2. Use: Exercise/ Persantine/ Lexiscan/ Dobutamine

Physician _____ Date _____

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Nuclear Cardiology Imaging

Patient Name _____ Age _____ DOB _____ Date _____

Family Doctor _____ Referring Doctor _____

Exercise Stress Test:

Bruce _____ Modified Bruce _____ Lexiscan _____ Dobutamine _____ Persantine _____

RISK FACTORS

1. Indication:*
2. Symptoms
3. Previous Cardiac Procedures:

- HYPERTENSION
- HYPERLIPIDEMIA
- SMOKER
- FAMILY HISTORY
- DIABETES
- OTHER _____

Resting EKG _____

Exercise Time _____ minutes _____ seconds METS _____ DP _____

Exercise was terminated due to _____ Exercise Tolerance _____

Resting HR _____ Max HR _____ %MPHR _____
 Resting BP _____ Peak BP _____ mm/Hg BP response _____

During Exercise:

- () Normal ECG response to exercise/ lexiscan/ dobutamine
- () ST depression consistent with ischemia LEADS _____
- () ST segment abnormalities occurred not interpreted due to _____

Arrhythmias noted () _____ () NONE

This is () Positive () Negative () Non-diagnostic stress test for ischemia

Rest Isotope Injected _____ Amount _____ Time Injected _____ Initials _____
 Stress Isotope Injected _____ Amount _____ Time Injected _____ Initials _____

Patient Height _____ inches Weight _____ Bra or Sport Coat Size _____
 Regadenoson 0.4mg _____ Dobutamine Dose _____ Persantine _____
 Aminophylline _____ Lopressor _____ Atropine _____

Physician interpreting _____ Date _____

Delaware Cardiovascular Associates

Nuclear Cardiology Imaging Patient Questionnaire

Name: _____ Date: _____

Family Doctor: _____ Cardiologist: _____

Are you a current smoker? Yes No Packs per day: _____

Are you a past smoker? Yes No Year quit: _____

Do you have any of the following?

_____ Coronary Artery Disease

_____ Stroke- When? _____

_____ Congestive Heart Failure

_____ Hear Attack- When? _____

_____ Abnormal EKG

_____ Chest pain/tightness/fullness

_____ Shortness of Breath

_____ Skipped Heart Beats (Arrhythmia)

_____ Palpitations (Heart Racing)

_____ Dizzy Spells

_____ Headaches

_____ Cardiac Catheterization- When? _____

_____ Stent Placement- When? _____

_____ Angioplasty- When? _____

_____ By-pass Surgery- When? _____ Number of vessels? _____

_____ High Blood Pressure

_____ High Cholesterol

_____ Diabetes

_____ Family History of Heart Disease _____ Mother _____ Father

Do you have an upcoming surgical procedure scheduled? Yes No

Have you ever had a **Nuclear** Stress Test before? Yes No

If yes, where _____ when _____

Please list any medications, over the counter drugs and supplements you take:
