Echocardiogram Stress Test Report

Medical Institution Details

Name: _____

Address: _____

Phone Number: _____

Website: _____

Patient Information

Full Name: _____

Date of Birth: _____/_____/_____

Gender: _____

Patient ID: _____

Contact Number: _____

Email Address: _____

Referring Physician

Name: _____

Specialty: _____

Contact Number: _____

Test Details

Date of Test: _____/_____/_____

Time of Test: _____

Technician: _____

Indications for Test: _____

Pre-Test Measurements

Resting Blood Pressure: _____

Resting Heart Rate: _____

ECG Findings at Rest: _____

Stress Test Protocol

Type (e.g., Bruce, Modified Bruce, etc.): _____

Duration of Exercise: _____

Maximum Heart Rate Achieved: _____

Blood Pressure Response: _____

ECG Changes: _____

Echocardiogram Findings

Pre-Stress Wall Motion: _____

Post-Stress Wall Motion: _____

Ejection Fraction: _____

Valvular Function: _____

Chamber Sizes: _____

Wall Thickness: _____

Other Findings: _____

Interpretation

Normal Response to Exercise: ☐ Yes ☐ No

Ischemic Response: ☐ Yes ☐ No

Arrhythmias Noted: ☐ Yes ☐ No

Wall Motion Abnormalities: ☐ Yes ☐ No

Other Abnormalities: _____

Physician's Comments

Recommendations

Follow-Up Tests: _____

Medication Adjustments: _____

Lifestyle Modifications: _____

Further Cardiac Evaluation: _____

Physician's Signature: _____ **Date:** _____/_____/_____

Patient Acknowledgment

I have been informed of the results and understand the recommendations provided.

Patient's Signature: _____

Date: _____/_____/_____
