

ARRHYTHMIA ASSOCIATES PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

Email: _____ Fax: _____

Primary Care Physician: _____

Cardiologist: _____

Reason for Visit: _____

Have you Experienced?

- Palpitation? (racing heart or skipped beats) No Yes When _____
- Fainting? No Yes When _____
- Near Fainting? No Yes When _____
- Shortness of Breath? No Yes When _____
- Chest discomfort? No Yes When _____
- Swelling of extremities? No Yes When _____

Have you been Diagnosed with?

- Heart attack (myocardial infarction)? No Yes When _____
- High blood pressure (hypertension)? No Yes When _____
- Diabetes? No Yes When _____
- Congestive heart failure? No Yes When _____
- Stroke? No Yes When _____

Have you had the following tests or procedures?

- Stress Test? No Yes When _____
- Echocardiogram (ultrasound of heart)? No Yes When _____
- Heart catheterization (angiogram)? No Yes When _____
- Electrophysiology study (EPS)? No Yes When _____
- Cardiac catheter ablation? No Yes When _____

Do you have a cardiac device implanted?

Do you have a pacemaker? No Yes When _____
Do you have a defibrillator? No Yes When _____
Bi-ventricular device No Yes When _____
Do you have regular follow-up? No Yes When _____
When followed up? _____ Who implanted? _____

Surgical History:

Type _____ Date _____
Type _____ Date _____
Type _____ Date _____

Do you have difficulty with anesthesia? No Yes

Explain: _____

List of Medications:

Allergies: No known allergies.

Social History

Marital Status Single Married Seperated Divorced Widow/er

Alcohol Use Never Daily How Much _____

Tobacco Use Never Daily How Much _____

Recreational Drug Use Never Daily How Much _____

Family Medical History

Father Deceased Age _____ Diseases _____

Mother Deceased Age _____ Diseases _____

Sibling Deceased Age _____ Diseases _____

Sibling Deceased Age _____ Diseases _____

Child Deceased Age _____ Diseases _____

Child Deceased Age _____ Diseases _____

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Sibling Deceased Age _____ Diseases _____

Sibling Deceased Age _____ Diseases _____

Child Deceased Age _____ Diseases _____

Child Deceased Age _____ Diseases _____

General Medical History - Check all that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> Recent weight gain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Recent weight Loss | <input type="checkbox"/> Palpations | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fatigue/Tiredness | <input type="checkbox"/> Swelling of Extremities | <input type="checkbox"/> Rectal bleeding |
| | <input type="checkbox"/> Dizziness/Light Headedness | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Blurred/Double vision | | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Spitting up blood | <input type="checkbox"/> Pain/burning urination |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Chronic/frequent cough | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Tinnitus | | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Nose bleed | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Rash/itching | <input type="checkbox"/> Muscle pain/cramps | <input type="checkbox"/> Male-Erectile dysfunction |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Back Pain | |
| | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Easy Bleeding/bruising | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Excessive thirst/urination |
| <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heat/Cold intolerance |

Please let the nurse know if there is something that is not listed, or write below.