

# 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 \_\_\_\_\_

**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      \_\_\_\_\_

**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.**