

**Wolf MiniMaze procedure questionnaire for information about your atrial fibrillation and medical history.**

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**Information we must have faxed to us for review:**

1. Your most recent cardiac tests and procedures (EKG, echocardiogram, cardiac catheterizations and stress tests). Reports must be within the last 6 months.
2. A list of current medications and the dosages, especially any anti- arrhythmics AND Coumadin
3. Your past medical and surgical history
4. If you have a pacemaker- specify type, brand and model (if possible)
5. Your current height and weight
6. Any other procedures used to treat your atrial fibrillation (i.e. cardioversions, catheter ablations)
7. We need a copy of your cardiac catheterization on a CD-Rom.  
Any information or reports on cardioversions or ablation. Reports:  
Any information on operative reports from any previous heart surgeries, any VQ scans, GXT ... Reports, and/or pulmonary history, if any.

In order to provide quick, accurate, and consistent correspondence, please include your telephone numbers, current mailing address and e-mail address (if you have one).

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**THIS IS A SECURE PAGE ALL INFORMATION WILL BE KEPT CONFIDENTIAL AS PRESCRIBED BY THE HIPAA ACT**

**MEDICAL HISTORY QUESTIONNAIRE**

**YOUR PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_ (mm/dd/yyyy)

Your Name: \_\_\_\_\_

Your Address:

Street \_\_\_\_\_

Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Date of birth: \_\_\_\_\_ (mm/dd/yyyy)

Age: \_\_\_\_\_

Gender : Male  Female

Weight \_\_\_\_\_ in pounds \_\_\_\_\_

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Social Security Number \_\_\_\_\_

XXX-XX-XXXX

HOME Phone Number with area code: \_\_\_\_\_

WORK Phone Number with area code: \_\_\_\_\_

CELL Phone Number with area code: \_\_\_\_\_

FAX Phone number with area code: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Patient employer \_\_\_\_\_

Patient Occupation \_\_\_\_\_

**PRIMARY CARE PHYSICIAN INFORMATION**

Your Doctor's:

Name: \_\_\_\_\_

Address:

Street \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone Number with area code: \_\_\_\_\_

FAX Number with area code: \_\_\_\_\_

Please make sure to include you Doctor's FAX number.

**CARDIOLOGIST INFORMATION**

Your Cardiologist's:

Name: \_\_\_\_\_

Address:

Street \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Telephone Number with area code: \_\_\_\_\_

FAX Number with area code: \_\_\_\_\_

Please make sure to include you Cardiologist's FAX number.

**PERSON WHO WILL BE COMING WITH THE PATIENT FOR THE PROCEDURE**

Name: \_\_\_\_\_

Relationship \_\_\_\_\_

Telephone Number with area code: \_\_\_\_\_

**YOUR INSURANCE COMPANY INFORMATION**

Please fax a copy of your insurance card, front and back, to 513-584-1538 attention Audrey

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number with area code: \_\_\_\_\_

Fax Number with area code: \_\_\_\_\_

Subscribers Name: \_\_\_\_\_

Members Name: \_\_\_\_\_  
 Group Name: \_\_\_\_\_  
 Coverage Type: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_  
 Effective Date: \_\_\_\_\_ (mm/dd/yyyy)  
 Group Name-(i.e. employer name): \_\_\_\_\_

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### Your Local Pharmacy Information

Name of Pharmacy \_\_\_\_\_  
 Phone number with area code: \_\_\_\_\_  
 FAX number with area code: \_\_\_\_\_

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### Please, check all boxes that apply to you

If you do not understand a question, then it probably means that you do not have the condition.

Check the boxes that pertain to your situation:

Do you have a cardiac history? Yes  No

- Hypertension (High blood pressure) Year Diagnosed \_\_\_\_\_ (yyyy)
- LVH (enlarged heart) without hypertension
- Coronary artery disease
- Angina (Chest pain on exertion)
- Previous Myocardial infarction (Heart attack) Date: \_\_\_\_\_ (mm/dd/yyyy)
- Idiopathic cardiomyopathy
- Tachycardia mediated cardiomyopathy
- Hypertrophic cardiomyopathy
- Heart Failure
- Valvular heart disease Date diagnosed \_\_\_\_\_ (mm/dd/yyyy)
- Endocarditis
- Pericarditis
- Congenital heart disease Type \_\_\_\_\_

Any previous heart surgery Type \_\_\_\_\_

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**Check the boxes that pertain to your situation:**

Do you have a pulmonary history? Yes  No

Chronic obstructive pulmonary disease.

What intensity: ONLY CHECK ONE

- Mild  
 Moderate  
 Severe
- 

Emphysema.

What intensity: ONLY CHECK ONE

- Mild  
 Moderate  
 Severe
- 

Asthma

Intensity: ONLY CHECK ONE

- Mild  
 Moderate  
 Severe
- 

Previous Pulmonary embolism

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**Check the boxes that pertain to your situation:**

Do you have a vascular history? Yes  No

Transient ischemic attack Year Diagnosed \_\_\_\_\_ (yyyy)

Reversible Ischemic Neurological Deficit Year Diagnosed \_\_\_\_\_ (yyyy)

Stroke Year Diagnosed \_\_\_\_\_ (yyyy)

Permanent neurological deficit Specify \_\_\_\_\_

Renal insufficiency

Peripheral vascular disease

Deep vein thrombosis

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**Check the boxes that pertain to your situation:**

Do you have an endocrine disease? Yes  No

Diabetes Mellitus Year Diagnosed \_\_\_\_\_ (yyyy)

Are you on Insulin? Yes  No

Hypothyroid? [ONLY CHECK ONE](#)

Hyperthyroid?

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**Atrial Fibrillation History**

What condition does your doctor say you have? \_\_\_\_\_

Are you in Atrial Fibrillation all of the time? Yes  No

If yes, for how long? \_\_\_\_\_

Or does your A Fib come and go? Yes  No  \_\_\_\_\_

If it comes and goes, how frequent are the episodes?

How Long have you had atrial fibrillation? \_\_\_\_\_

Are you aware of it when you are in AF? Yes  No

Have you had a previous cardioversion? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Have you had a previous EP Study? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Have you had a previous cardiac ablation? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Have you had a previous echocardiogram? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Have you had a previous stress test? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Have you had a previous cardiac catheterization? Yes  No

If yes, when was the last one? \_\_\_\_\_ (mm/dd/yyyy)

Do you have a pacemaker? Yes  No

If yes, please specify type, brand and model (if possible) \_\_\_\_\_

**List of All Current Medications:**

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Medication Name:  Dosage:  Frequency:   
Reason:

Are you allergic to any medications? Yes  No

If your answer is yes, please list the medications that you are allergic to in the window below.

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**Surgical Procedures**

List all surgical procedures you have had and the year they were performed.

