

Today's Date: ____/____/____ (MM/DD/YY)

Personal Information

Patient's
Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Home Phone: () _____ Cell Phone: () _____

E-mail Address: _____ Social Security #: _____

Birth Date: ____/____/____ Gender: Male Female Ethnic: Caucasian Black
MM / DD / YY Group: Asian Hispanic

Emergency Contact Name: _____ Emergency Contact Cell Phone: () _____

Primary Care Practitioner

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Suite/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Office Phone: () _____ Office Fax: () _____

Cardiologist

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Suite/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Office Phone: () _____ Office Fax: () _____

Electrophysiologist

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Suite/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Office Phone: () _____ Office Fax: () _____

E-mail Address: _____

Pharmacy

Name: _____

Address: _____
Street Address *Suite/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Phone: () _____ Fax: () _____

Social, Family and Allergy History

- Alcohol use? No Yes If Yes # drinks/week = _____
- Tobacco use? Never used or Stopped _____ Yes If Yes ____packs/day X ____ years
MM / YY
- Current/Previous Employment: _____
- Family history of AF? No Yes
If Yes specify _____
- Family history of heart disease/heart surgery? No Yes
If Yes specify _____
- Family history of other serious diseases? No Yes
If Yes specify _____

- Allergy to medication or food? No Yes
If Yes specify and give type of reaction:

Medication History

Current Medications:

Medication Name:	_____	Dosage:	_____	Frequency:	_____
Reason taking med:	_____				
Medication Name:	_____	Dosage:	_____	Frequency:	_____
Reason taking med:	_____				
Medication Name:	_____	Dosage:	_____	Frequency:	_____
Reason taking med:	_____				
Medication Name:	_____	Dosage:	_____	Frequency:	_____
Reason taking med:	_____				
Medication Name:	_____	Dosage:	_____	Frequency:	_____
Reason taking med:	_____				

Previous Antiarrhythmic Medications:

Medication Name:	_____	Reason Discontinued:	_____
Medication Name:	_____	Reason Discontinued:	_____