

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

*MM / DD / YY*

Gender:  Male  Female

Ethnic

Caucasian

Black

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: ( )

Referral Source:  Self Referred  PCP  Cardiologist  EP  Other \_\_\_\_\_

### Reason for Consult

In own words:

- Duration of AF? Paroxysmal (comes and goes) \_\_\_\_\_ Years  
Continuous (all the time) \_\_\_\_\_ Years  
Total number of years with AF \_\_\_\_\_ Years

### History of A Fib

In own words:

• **Your Height:** \_\_\_\_\_ **Your Weight:** \_\_\_\_\_

- Do you have any symptoms when you're in A Fib?  No  Yes  
If Yes, describe: \_\_\_\_\_

What is your quality of life with AF?:  
(Please circle one number)      Bad    → Fair    →    Excellent  
1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

- Do you have any other Heart Disease?  No  Yes  
If Yes, describe: \_\_\_\_\_
- Do you have any other Medical Problems?  No  Yes  
If Yes, describe: \_\_\_\_\_
- Have you had any Previous Surgeries?  No  Yes  
If Yes, Specify: \_\_\_\_\_
- Previous neurological episode (stroke/TIA)?  No  Yes  
If Yes, Specify: \_\_\_\_\_

=====

### Have you had?

- Previous Cardioversion?  No  Yes If Yes  
Where done & by whom: \_\_\_\_\_  
Date done   /  /    
                  MM / DD / YY
- Previous Echocardiogram?  No  Yes If Yes,  
Date done   /  /    
                  MM / DD / YY
- Previous Stress Test?  No  Yes If Yes  
Where done & by whom: \_\_\_\_\_  
Date done   /  /    
                  MM / DD / YY
- Previous Cardiac Cath?  No  Yes If Yes  
Where done & by whom: \_\_\_\_\_  
Date done   /  /    
                  MM / DD / YY
- Previous Ablations?  No  Yes  
Where done & by whom: \_\_\_\_\_  
Date done   /  /    
                  MM / DD / YY

## Social, Family and Allergy History

- Current Alcohol use?  No  Yes If Yes # drinks/week = \_\_\_\_\_
- Tobacco use?  Yes  Never used or Stopped \_\_\_\_\_  
If Yes or stopped \_\_\_\_\_ 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:	_____