

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: | _____ |