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 Group: □ Caucasian □ Black □ 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?: Bad ➔ Fair ➔ Excellent
  (Please circle one number) **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 _____ *MM / YY*
  If Yes or stopped ____packs/day X _____ years
- 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: _____

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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: _____