Arrhythmia Management Institute of South Florida

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Clinical & Invasive Cardiac Electrophysiology

NEW PATIENT QUESTIONNAIRE

DATE _____

NAME: _____ SEX: M F DOB: _____ AGE: _____

PRESENT ILLNESS (Why are you here today?): _____

_____

PAST CARDIOVASCULAR HISTORY

DISEASE/CONDITION	YES	NO	TREATMENT	SURGERY/PROCEDURE	YES	NO	DATE(s)
HEART MURMUR	YES	NO		EKG	YES	NO	
PALPITATIONS	YES	NO		CARDIOVERSON	YES	NO	
LOSS OF CONSCIOUSNESS	YES	NO		PACEMAKER	YES	NO	
STROKE/TIA	YES	NO		DEFIBRILLATOR	YES	NO	
TACHYCARDIA	YES	NO		ECHOCARDIOGRAM	YES	NO	
SUPRAVENTRICULAR TACHYCARDIA (SVT)	YES	NO		ABLATION: TYPE?	YES	NO	
ARRHYTHMIA: TYPE?	YES	NO		STRESS TEST: TYPE?	YES	NO	
HEART DISEASE: TYPE?	YES	NO		CARDIAC CATH: TYPE?	YES	NO	
HEART FAILURE: TYPE?	YES	NO		STENTS(s): WHERE?	YES	NO	
SLEEP APNEA	YES	NO		SLEEP STUDY	YES	NO	
EDEMA	YES	NO		BYPASS SURGERY	YES	NO	
ANGINA	YES	NO		ANGIOPLASTY	YES	NO	
CHEST PAIN	YES	NO		VALVE SURGERY/REPAIR	YES	NO	
CORONARY ARTERY DISEASE	YES	NO		CORONARY CT	YES	NO	
HEART ATTACK	YES	NO		CHEST X-RAY	YES	NO	
PERIPHERAL VASCULAR DISEASE (PVD)	YES	NO		CAROTID ULTRASOUND	YES	NO	
LIPID/CHOLESTEROL	YES	NO		OTHER	YES	NO	
HIGH BLOOD PRESSURE	YES	NO		OTHER	YES	NO	
ANEURYSM:	YES	NO		OTHER	YES	NO	

SOCIAL & FAMILY HISTORY

SOCIAL HISTORY	YES	NO	AMOUNT/QUIT WHEN?	FAMILY HISTORY	YES	NO	WHO?
CAFFEINE	YES	NO		ARRHYTHMIAS	YES	NO	
ALCOHOL	YES	NO		SUDDEN/PREMATURE DEATH	YES	NO	
TOBACCO	YES	NO		HEART FAILURE	YES	NO	
SUBSTANCE ABUSE	YES	NO		HIGH BLOOD PRESSURE	YES	NO	
COCAINE	YES	NO		HEART ATTACK/CAD	YES	NO	
EXERCISE	YES	NO		HIGH CHOLESTEROL	YES	NO	
TATTOOS	YES	NO		ALCOHOLISM	YES	NO	
BLOOD TRANSFUSIONS	YES	NO		DIABETIS	YES	NO	
EXERCISE	YES	NO		BLOOD CLOTS	YES	NO	
PROFESSION				CANCER	YES	NO	

PAST MEDICAL/SURGICAL HISTORY

MEDICAL HISTORY	YES	NO	TREATMENT	SURGICAL HISTORY	YES	NO	DATE
ARTHRITIS	YES	NO		ORTHOPEDIC	YES	NO	
ASTHMA	YES	NO		CHEST	YES	NO	
BLEEDING DISORDER	YES	NO		LUNG	YES	NO	
BLOOD CLOTS/DISORGER	YES	NO		STOMACH	YES	NO	
CANCER, TYPE:	YES	NO		INTESTINE/COLON	YES	NO	
INFLAMMATORY BOWEL DISEASE	YES	NO		GALLBLADDER	YES	NO	
DIABETES	YES	NO		JOINT REPLACEMENT	YES	NO	
EPILESPY/SEIZURES	YES	NO		HYSTERECTOMY	YES	NO	
GALLSTONES	YES	NO		APPENDIX	YES	NO	
GLAUCOMA	YES	NO		PROSTATE	YES	NO	
HEADACHES	YES	NO		BLADDER	YES	NO	
HEPATITIS/LIVER DISEASE	YES	NO		C-SECTION	YES	NO	
HIATAL HERNIA/GERD	YES	NO		BREAST	YES	NO	
LOW BLOOD PRESSURE	YES	NO		HEAD	YES	NO	
KIDNEY DISEASE	YES	NO		SKIN	YES	NO	
LUNG DISEASE	YES	NO		TRAUMA	YES	NO	
STOMACH PROBLEMS/ULCERS	YES	NO		ANESTHESIA PROBLEMS	YES	NO	
THYROID PROBLEMS	YES	NO		OTHER SURGERY	YES	NO	
TUBERCULOSIS	YES	NO		OTHER SURGERY	YES	NO	
INFECTIOUS DISEASE	YES	NO		OTHER SURGERY	YES	NO	
OTHER DISEASE:	YES	NO		OTHER SURGERY	YES	NO	

MEDICATIONS & ALLERGIES: Please include vitamins, herbs, pain relievers and recent antibiotics

MEDICATION	DOSE	FREQUENCY	ALLERGIES	REACTION TYPE

NOTES/COMMENTS:

REVIEW OF SYSTEMS: check all that apply

□ DIZZINESS	□ SWALLOWING DIFFICULTY	□ NASAL CONGESTION	□ DRY MOUTH
□ PALPITATIONS	□ WEIGHT CHANGE	□ HEARING LOSS	□ EXCESSIVE THIRST
□ FAINTING	□ FEVER / CHILLS	□ NAUSEA/VOMITING	□ JOINT PAIN
□ SHORTNESS OF BREATH	□ COUGH	□ ABDOMINAL PAIN	□ MUSCLE ACHES
□ SWELLING OF ANKLES/LEGS	□ POOR VISION / DOUBLE VISION	□ DIARRHEA	□ NEW/CHRONIC RASH
□ CHEST PAIN	□ HEADACHES	□ CONSTIPATION	□ SWOLLEN LYMPH NODES
□ HEARTBURN	□ ANXIETY	□ FREQUENT URINATION	□ NAIL CHANGES
□ FREQUENT NOSEBLEEDS	□ SEIZURES	□ INCONTINENCE	□ HAIR LOSS
□ EXCESSIVE BLEEDING	□ DEPRESSION	□ BLOOD IN URINE	□ HOT/COLD SENSITIVITY
□ EASY BRUISING	□ MEMORY LOSS	□ BLOOD IN STOOL	□ BLUE FINGERS/TOES

IS THERE ANYTHING ELSE YOU WOULD LIKE THE DOCTOR TO KNOW ABOUT YOUR HEALTH:

WHAT PHARMACY DO YOU USE: NAME/LOCATION/PHONE/FAX

PHYSICIANS WHO ARE ACTIVELY TREATING YOU: NAME/PHONE/FAX

PRIMARY CARE PHYSICIAN			
CARDIOLOGIST			

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

PHYSICIAN's NOTES: