Please fill out the following questionnaire and bring it with you to your first consultation appointment. This medical history information will help us get to know you and formulate the most appropriate plan of care.

**Current medications** (Include dosage and frequency):
_________________________  ___________________________
_________________________  ___________________________
_________________________  ___________________________

Any prior anti-arrhythmic medications attempted or discontinued (include dates if known):
_________________________  ___________________________

Any previous procedures (ie: cardiac ablations, cardioversions) with dates:
_________________________  ___________________________

**Allergies** (to meds, other substances, etc):
_________________________  ___________________________
_________________________  ___________________________

**Past Medical History:**
Prior surgeries? When?
_________________________

Prior hospitalizations? When? For what?
_________________________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Do you have hypertension?</td>
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<td>Do you have cardiac valve disease?</td>
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<td>Do you have congestive heart failure?</td>
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<td>Have you ever had a heart attack?</td>
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<td>Do you have swelling in your ankles or feet?</td>
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<td>Do you have coronary artery disease?</td>
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<td>Do you have palpitations?</td>
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<td>Have you ever lost consciousness?</td>
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<td>Do you get lightheaded or dizzy?</td>
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<td>Do you have chest pain?</td>
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<td>Do you have trouble sleeping flat?</td>
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<td>Have you been experiencing a decrease in exercise tolerance?</td>
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<tr>
<td>Do you have a pacemaker or implantable defibrillator? If yes,</td>
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<tr>
<td>Type of device (circle): Pacemaker  Defibrillator  Company if known:</td>
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</table>

How far can you walk (Please quantify in feet, miles, or city blocks)?
__________________________________________________________________
**Family History:** (Your father, mother, siblings, children)

Any history of sudden cardiac death or early coronary artery disease?  
Yes  No

If yes, please list who, age, and cause of death:

______________________________________________________________________

**Social History:**

Occupation: ____________________________  
Marital status: ____________________________  
Number of Children: ____________________________

Do you smoke?  No  Yes  How much?  How long?  
Do you drink alcohol?  No  Yes  How much?  How long?  
Do you use illicit drugs?  No  Yes

**Review of Systems:** (Check only if yes; leave blank if no)

_____ Have you had recent fever or chills?  
_____ Any recent weight changes?  
_____ Have you ever been diagnosed with sleep apnea?  If yes, do you use CPAP?  No  Yes

_____ Do you wear glasses?  
_____ Have you had any recent visual changes?  If yes, please describe ____________________________

_____ Do you have any hearing loss?  
_____ Do you get any earaches?  
_____ Do you have difficulty swallowing?

_____ Do you have a cough productive of sputum?  
_____ Do you have wheezing?  
_____ Have you had shortness of breath?  
_____ Have you had hemoptysis (coughing up blood-tinged sputum)?  
_____ Have you had pneumonia or bronchitis?  
_____ Have you had radiation therapy to the chest region?

_____ Have you had stomach ulcers?  
_____ Do you have heartburn, reflux, or GERD (gastroesophageal reflux disease)?  
_____ Have you had recent nausea or vomiting?  
_____ Do you have any abdominal pain?

_____ Did you have any difficulty with urination?  
_____ Have you ever had any blood in the urine?

_____ Do you have arthritis?  
_____ Do you have any pain or cramping in the back of legs with walking?  
_____ Do you have any skin rashes?  
_____ Have you noticed any yellowing of your skin or change in skin color?

_____ Have you ever had any sudden weakness or numbness on one side of the body?  
_____ Have you ever had a stroke?

_____ Do you have diabetes?  
_____ Do you have any thyroid problems?  

_____ Do you have anxiety or panic attacks?  
_____ Do you have depression?