Interior Health

TRIAL

NEW PATIENT INFORMATION FORM
Heart Rhythm Clinic

Patient Name *(last)* _____

(first) _____

DOB *(dd/mmm/yyyy)* _____

PHN _____ MRN _____

Account / Visit # _____

IH USE ONLY

Height _____ Weight _____ Visit Date _____ **For office use:** BP: ____ Arm: ☐ L ☐ R Signature _____

Why do you think your Doctor has sent you to see an electrophysiologist (EP)? _____

Doctors you would like copies of my letter sent to _____

Past Medical History

Previous documented irregular / abnormal heart rhythm: ☐ Supraventricular Tachycardia (SVT) ☐ Atrial Fibrillation ☐ Atrial Flutter ☐ Ventricular Tachycardia

Previous Cardiac ablation / EP procedure ☐ NO ☐ YES; how many and when? _____

Previous Pacemaker or Defibrillator / ICD: ☐ NO ☐ YES; date implanted _____

Company of Pacemaker / ICD this can be found on your pacemaker ID card:
☐ Guidant ☐ Medtronic ☐ St. Jude Medical ☐ Uncertain ☐ Other _____

Previous Heart Attack: ☐ NO ☐ YES; when _____

Previous coronary stents: ☐ NO ☐ YES; when / where _____

previous Coronary Angiogram / stents ☐ NO ☐ YES; when / where _____

Previous Stroke or TIA (mini-stroke): ☐ NO ☐ YES; when _____

Medical Conditions: ☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Kidney Disease ☐ Asthma ☐ Heart Failure (CHF) ☐ Sleep Apnea (OSA) ☐ CPAP used

Previous bleeding requiring surgery or blood transfusion (describe if yes):
☐ NO ☐ YES _____

List any other previous surgeries _____

List any other medical problems _____

Current Medications *(please list all medications and dosage; example: Metoprolol 100 mg twice a day)*

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Allergies to any medications / adverse reactions including: for example intravenous contrast / iodine, shellfish or latex:
☐ None ☐ Uncertain ☐ YES (please list) _____

Social History

Smoking: ☐ Never Smoked ☐ Quit Smoking – year ____ ; years smoked ____ ☐ Current Smoker: how much: _____

Alcohol Consumption (how many drinks per week?): _____

Caffeine consumption (how many per day?): _____

Any recreational drugs (marijuana, cocaine, etc): _____

Current Employment: _____

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Social History *(continued)*

Do you drive? ☐ NO ☐ YES ☐ Currently told not to

Do you hold a professional (truck, taxi, bus) drivers license? ☐ NO ☐ YES

Would you accept a blood transfusion? ☐ NO ☐ YES

Are you planning to travel outside of Canada in the next 6 months? ☐ NO ☐ YES

Family History

Does anyone in your family have a problem with their heart? if yes

What is it _____

What age did it happen? _____

Have there been any young, sudden or unexplained deaths in the family? ☐ NO ☐ UNCERTAIN ☐ YES (describe if yes)

_____

Personal History Are you currently having any of the following:

1. Palpitations (feeling of rapid or irregular heartbeat) ☐ NO ☐ YES _____
   - How long have you been aware of this? _____
   - Have the palpitations ever cause you to go to emergency? _____
   - Do the palpitations have a sudden onset and termination? _____
   - Does it happen at rest, exercise, both? _____
   - Are there any triggers or things that provoke palpitations? _____
   - Are you able to stop them and how? _____
   - How often do they occur? _____
   - How long is a typical episode? (range of shortest to longest) _____
2. Chest Pain or tightness with exertion ☐ NO ☐ YES _____
3. Chest Pain or tightness at rest ☐ NO ☐ YES _____
4. Shortness of breath with exertion ☐ NO ☐ YES _____
5. Shortness of breath at rest ☐ NO ☐ YES _____
6. Shortness of breath at night ☐ NO ☐ YES _____
7. Do you sleep propped up? ☐ NO ☐ YES _____
8. Do you get swelling in your ankles? ☐ NO ☐ YES _____
9. Have you ever fainted before? ☐ NO ☐ YES _____

Have you experienced any of the above previously, but now these have stopped, please describe:

☐ This document has been filled out to the best of my knowledge: _____ initials

Information Verified by (Provider signature): _____