Arrhythmia Consultants of Connecticut

Patient Health Information Sheet
(Please complete both sides)

Name: _____ Date of birth: _____ Age: _____

Gender: ☐ Male ☐ Female Today's date: _____

Occupation: _____

Part I: Medications and Nutritional Supplements. *Please list all medications that you take on a regular basis. Please include vitamins, mineral, nutritional supplements, over-the-counter medications, and medications you only take "as needed."*

Name	Dosage	Times per day

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Part II: Past Medical History and Review of Systems (if yes, please explain)

☐ Chills
☐ Fatigue
☐ Fever
☐ Weight change
☐ Congestion
☐ Hearing loss
☐ Sore throat
☐ Ringing in ears
☐ Visual disturbance
☐ Chest tightness
☐ Cough
☐ Shortness of breath
☐ Wheezing
☐ Chest pain
☐ Leg swelling
☐ Palpitations
☐ Abdominal pain
☐ Blood in stool
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting
☐ Cold intolerance
☐ Difficulty urinating
☐ Pain with urination
☐ Frequent urination
☐ Blood in urine
☐ Joint pain
☐ Back pain
☐ Pale skin
☐ Skin rash
☐ Skin wounds
☐ Food allergies
☐ Dizziness
☐ Headache
☐ Light-headedness
☐ Numbness
☐ Seizures
☐ Fainting
☐ Tremors
☐ Weakness
☐ Easy bruising
☐ Confusion
☐ Decreased concentration
☐ Anxiety

Comments

Please turn over and complete side two.

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Part III: Allergies

Do you have allergies to food or medications? ☐ Yes

If yes, please explain below. Include the reaction you had, and any treatment that was required.

_____ _____ _____

_____ _____ _____

Part IV: Anesthesia history

Have you ever had a problem with:	Do you currently have a problem with:
☐ Anesthesia/sedatior	☐ Lying flat
☐ Iodine	☐ Head, neck or back pain
☐ Valium type drugs	☐ Loose teeth or dentures
☐ Bleeding after surgery or dental work	☐ Difficulty breathing through your nose?

Part V: Hospitalizations and/or Major Illnesses

Reason for hospitalization / illness	Date(s)	Hospital name

Part VI: Family History

	Age(s)	Living/Deceased	Major illnesses or cause of death
Mother		☐ L ☐ D	
Father		☐ L ☐ D	
Brother(s)		☐ L ☐ D	
Sister(s)		☐ L ☐ D	
Children		☐ L ☐ D	

Has anyone in your family ever had:

☐ Fainting/Seizures ☐ WPW (Wolff-Parkinson-White) ☐ Unexpeced Death

Comments:

Part VIII: Habits

	Do you currently?	Have you ever?	If yes, how much / for how long?	If you stopped, when?
Smoking				
Alcohol				
Caffeinated foods / drinks*				
Illegal drugs (specify)				
Stressful lifestyle				

Please do not write below this line.

Physician's signature: _____ **Date:** _____