Medical Associates
PRIMARY CARE
A MULTISPECIALTY GROUP
"THE CARE YOU CAN TRUST"

UCLA Cardiac Arrhythmia Center Outpatient Questionnaire

Department of Medicine/Division of Cardiology

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?

_____
_____

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

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?