

DUKE CLINICAL ELECTROPHYSIOLOGY HEALTH INVENTORY

Instructions: Please complete this form and bring it with you to your clinic appointment.
This information will help us provide a more complete health care assessment.

Name: _____ DOB: _____
Duke History Number: _____
Phone: Home (____) _____ Work: (____) _____
Cell: (____) _____ Email: _____
Address: _____

May we leave messages concerning your medical appointments/care on voice mail, email and/or with other family members/partners? ____ YES or ____ NO

If so, please sign: _____ Date: _____

Referring Physician: _____ Phone: (____) _____
Primary Physician: _____ Phone: (____) _____
Pharmacy: _____ Phone: (____) _____ Fax: (____) _____

Symptoms for which you are being seen: _____

Medical Problems: Please check below if you have ever been treated for the following medical conditions.

___ Abnormal Chest X-ray	___ Emphysema	___ Palpitations
___ Anxiety	___ Heart attack	___ Peptic ulcer disease
___ Heart failure	___ Pneumonia	___ Heart murmur
___ Psychosis	___ Asthma	___ Hepatitis
___ Back pain	___ High blood pressure	___ Seizures
___ High cholesterol	___ Stroke/mini stroke	___ Bronchitis
___ Irregular heart beats	___ Thyroid disease	___ Cancer
___ Kidney disease	___ Depression	___ Menopause
___ Diabetes		
___ Other: _____		

Please list any surgeries or trauma you have had including type and date: _____

Have you ever had problems with anesthesia or pain medication? Yes ____ No ____
Please describe: _____

Please list any food, drug, or intravenous dye (kidney, cardiac) allergies and explain the reaction:

Please list all current medications, (including non-prescription medicines or herbal supplements) with dosage and time(s) taken:

Name:	Dose:	Time:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide the following information about your family's health history: **(current age or age at death; current health problems or cause of death).**

Father: _____
 Mother: _____
 Siblings: _____
 Children: _____

Is there any family history of heart attack before age 60, sudden death, fainting, palpitations or Long QT syndrome? _____

Personal History:

Years of education: _____ Occupation: _____
 Hobbies / sports: _____
 Marital status: _____ Right or left handed: _____

Please check the following habits that apply to you and explain type, amount and number of years:

	<u>Type</u>	<u>Amount</u>	<u>Number of years</u>
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Recreational or street drugs	_____	_____	_____
Caffeine	_____	_____	_____
Over counter medications	_____	_____	_____
Coumadin or blood thinners (Ticlid, Warfarin)	_____	_____	_____

Please place a check by any of the problems below that you have had. Use the space below to explain fully.

___ Depression	___ Night sweats	___ Dizziness
___ Weakness / fatigue	___ Fever	___ Stress / anxiety
___ Weight change		

Please explain: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain / pressure | <input type="checkbox"/> Passing out | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Previous heart failure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Skipped beats | <input type="checkbox"/> Previous heart attack | <input type="checkbox"/> Slow heart beat |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Irregular heart beats | <input type="checkbox"/> Near passing out |
| <input type="checkbox"/> Swelling in hands/feet | <input type="checkbox"/> Leg cramps with exercise | <input type="checkbox"/> Decrease in amount of exertion you can do |

Explain: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Trouble breathing lying flat |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Trouble breathing at night |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Sleep sitting up | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sputum / phlegm | |

Explain: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood in urine / stool | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Problems swallowing |
| <input type="checkbox"/> Black tarry stools | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Past ulcers |
| <input type="checkbox"/> Changes in bowel habits | <input type="checkbox"/> History of hepatitis | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Diarrhea / constipation | <input type="checkbox"/> Indigestion /heartburn | <input type="checkbox"/> Nausea / vomiting |
| <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Kidney problems | | |

Explain: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Voice changes |
| <input type="checkbox"/> Vertigo/ dizziness | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Easy bruising / bleeding | | |

Explain: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Feeling warmer than others | <input type="checkbox"/> Feeling colder than others |
|---|---|---|

Explain: _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Memory changes | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Previous stroke |
| <input type="checkbox"/> Problems with balance | <input type="checkbox"/> Breast lumps /masses | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Problems walking |
| <input type="checkbox"/> Muscle weakness (arm/hand/leg/other) | | |

Explain: _____

If female please complete:

- | | | |
|---|--|------------------------------------|
| <input type="checkbox"/> Abnormal pregnancies | <input type="checkbox"/> Abnormal labor/delivery | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Menstrual difficulties | <input type="checkbox"/> Date of last menstrual period | |

Explain: _____

Please check any of the following test / procedures that you have had performed, list the place done and approximate date:

- | | Institution: | Date: |
|--|--------------|-------|
| <input type="checkbox"/> Echocardiogram (heart ultrasound) | _____ | _____ |
| <input type="checkbox"/> Loop or event heart monitor | _____ | _____ |
| <input type="checkbox"/> Heart catheterization | _____ | _____ |
| <input type="checkbox"/> Pacemaker | _____ | _____ |
| <input type="checkbox"/> Cholesterol check | _____ | _____ |
| <input type="checkbox"/> Tilt table | _____ | _____ |
| <input type="checkbox"/> Continuous heart monitor (Holter) | _____ | _____ |
| <input type="checkbox"/> Exercise stress test | _____ | _____ |
| <input type="checkbox"/> Electrophysiology study | _____ | _____ |
| <input type="checkbox"/> Implantable defibrillator | _____ | _____ |
| <input type="checkbox"/> Blood thyroid check | _____ | _____ |

Thank you for your assistance and remember to bring this with you to your scheduled appointment.