ARIZONA ARRHYTHMIA CONSULTANTS

Patient Name: _____

DOB: _____

Date: _____

Health History Update

Please check YES or NO if any symptoms are *currently present*

NOTE: Please do not leave any blanks

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cardiac:			**Respiratory:**			**Psychiatric:**		
Chest Pains			Snoring			Depression		
Palpitations			Hemoptysis (Coughing up blood)			Hallucinations		
Diaphoresis (Excessive sweating)			Dyspnea (shortness of breath)			**Hematologic:**		
Syncope (fainting)			**Gastrointestinal:**			Acute Anemia		
Orthopnea (Difficulty breathing laying down)			Nausea			Thrombocytopenia (low blood platelet count)		
PND (breathing disorder related to CHF)			Reflux			**Endocrine:**		
Vascular:			Bleeding			Goiter (enlarged thyroid)		
Claudication (Pain or limping in legs)			**Genitourinary:**			Tremors		
Edema or Swelling			Hematuria (Blood in urine)			**Derm:**		
Constitutional:			Frequent urination at night (>2 times/night)			Rash		
Weight gain			**Neurological:**			Skin Sores		
Weight loss			Dizziness			**Musculoskeletal:**		
Fever			Memory loss			Joint Pain		
HEENT: (Head, Ears, Nose & Throat)			Seizures			Myalgia (muscle pain)		
Visual Changes			**Reproductive:**					
Hearing loss			HX of oral contraception (Birth Control Pills)					