ARIZONA ARRHYTHMIA CONSULTANTS™

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)					

Patient Name: ____

Date of Birth: ____________**Height**: _______________ **Weight**: ____________________

(Please see & complete page 2)

Please list any medication changes *SINCE YOUR LAST VISIT*:

Name:	Dosage/Frequency:	Name:	Dosage/Frequency:
(None)			

Have you been admitted to the hospital *SINCE YOUR LAST VISIT?*

- ○ **No**
- ○ **Yes**
  - **If yes, when:** ____
  - **Which hospital?** ____
  - **For what reason?** ____

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Pharmacy Information:

Local Pharmacy Name: ____

Address: ____

Phone: ____

Mail-Order Pharmacy Name: ____

Address: ____

Phone: ____

Patient Name: ______________________________**Date of Birth**: ______________________________