



Washington **Heart** Rhythm Associates, LLC

Pirooz Mofrad MD, FACC, FHRS
10230 New Hampshire Avenue, Suite 204
Silver Spring, MD 20903
Telephone: 301-408-7890 Fax: 301-408-7892

NEW CLINIC PATIENT QUESTIONNAIRE

Name (Last, First)		Birthdate	Age	Sex M F
Appointment Date	Clinic Physician			
Did another physician refer you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Self-Referral Referring MD Name _____ Street Address _____ City, State, Zip Code _____ Phone () _____ Fax () _____				
If you have a primary physician, other than the referring physician, please complete so we can send them a report of your office visit Primary Care MD Name _____ Street Address _____ City, State, Zip Code _____ Phone () _____ Fax () _____				
Would you like this clinic's visit information sent to any physician other than those listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No MD Name _____ Street Address _____ City, State, Zip Code _____ Phone () _____ Fax () _____				
What is the reason for your clinic appointment today? _____ _____ _____ _____ _____				
<u>Past Medical History</u>				

Please indicate if you have ever been **diagnosed** with any of the following conditions. If Yes, please give an explanation.

SYSTEM	YES	NO	PATIENT COMMENTS
<i>CARDIOVASCULAR</i>			
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Carotid Artery Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Surgery/Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Prosthetic/Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	
Blockage of Arm/Leg Vessels	<input type="checkbox"/>	<input type="checkbox"/>	
<i>GASTROINTESTINAL/ GENITOURINARY/ RESPIRATORY</i>			
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
<i>OTHER</i>			
Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Toxic Exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER PAST MEDICAL HISTORY (Please list all medical conditions not mentioned above) _____

PREVIOUS OPERATIONS/HOSPITALIZATIONS:

Date	Hospital	Problem/Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS (Please list all medications, i.e. over-counter medications and herbal meds)

Medications	Dosage	Number Taken Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy History

Have you ever had an allergic reaction to any medication? Yes No If yes, please list medication and reaction.

Social History

Birthplace: _____ Highest Grade completed in School: _____

Current Occupation: _____

Relationship/Marital status: _____

Have you ever smoked cigarettes: Yes No

If yes, how much do you currently smoke per day? ½ pack 1 pack 2 packs > 2 packs

If you previously smoked, how long ago did you quit? 1 year 1-5 years > 5 years

How many years did you smoke? _____

Have you had significant exposure to: Pesticides? Yes No

Do you drink alcohol? Yes No Type_____ How often/much? _____

Do you exercise? Yes No If yes, how much? Rarely Occasionally >3 times/week

Dietary Restrictions? _____

Family History:

<i>Family Member</i>	<i>Age (or age at death)</i>	<i>Medical Problems</i>
Grandparents	_____	_____
	_____	_____
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____

Review of Systems

Have you experienced any of the following symptoms? Please circle Yes, No, or Unknown. If Yes, please give an explanation.

SYSTEM	Patient: Circle Response	Physician / Patient Comments
ALLERGY/IMMUNOLOGY		<input type="checkbox"/> WNL
Low resistance to infection	YES NO UNKNOWN	
Environmental allergies	YES NO UNKNOWN	
CARDIOVASCULAR		<input type="checkbox"/> WNL
Chest pain or angina	YES NO UNKNOWN	
Irregular heart rhythm	YES NO UNKNOWN	
Swelling of the feet, ankles, hands	YES NO UNKNOWN	
CONSTITUTIONAL		<input type="checkbox"/> WNL
Good general health lately	YES NO UNKNOWN	
Recent weight changes	YES NO UNKNOWN	
Extreme fatigue	YES NO UNKNOWN	
Frequent nausea, vomiting	YES NO UNKNOWN	
Difficulty sleeping	YES NO UNKNOWN	
EARS, NOSE, MOUTH, THROAT		<input type="checkbox"/> WNL
Change in hearing	YES NO UNKNOWN	
Ringing in the ears	YES NO UNKNOWN	
Recent nose bleeds	YES NO UNKNOWN	
Chronic sinus problems	YES NO UNKNOWN	
Voice changes	YES NO UNKNOWN	
EYES		<input type="checkbox"/> WNL
Wear glasses, contact lenses	YES NO UNKNOWN	
Change in vision	YES NO UNKNOWN	
Glaucoma	YES NO UNKNOWN	
ENDOCRINE		<input type="checkbox"/> WNL
Heat or cold intolerance	YES NO UNKNOWN	
Excess thirst or urination	YES NO UNKNOWN	
GASTROINTESTINAL		<input type="checkbox"/> WNL
Change in appetite	YES NO UNKNOWN	
Severe heart burn	YES NO UNKNOWN	
Vomiting blood	YES NO UNKNOWN	
Frequent diarrhea	YES NO UNKNOWN	
Constipation	YES NO UNKNOWN	
Black or bloody stools	YES NO UNKNOWN	
Abdominal pain	YES NO UNKNOWN	

SYSTEM	Patient: Circle Response	Physician / Patient Comments
GENITOURINARY		<input type="checkbox"/> WNL
Blood in urine	YES NO UNKNOWN	
Burning with urination	YES NO UNKNOWN	
Difficult/frequent urination	YES NO UNKNOWN	
Lack of bladder control	YES NO UNKNOWN	
Sexually transmitted disease	YES NO UNKNOWN	
Change in sexual function	YES NO UNKNOWN	
HEMATOLOGY/LYMPHATIC		<input type="checkbox"/> WNL
Easy bruising	YES NO UNKNOWN	
Frequent bleeding	YES NO UNKNOWN	
Enlarged lymph nodes	YES NO UNKNOWN	
INTEGUMENTARY SKIN & BREASTS		<input type="checkbox"/> WNL
Unusual or prolonged rashes	YES NO UNKNOWN	
Breast pain or lump	YES NO UNKNOWN	
Change in hair or nails	YES NO UNKNOWN	
MUSCULOSKELETAL		<input type="checkbox"/> WNL
Joint/muscle stiffness or pain	YES NO UNKNOWN	
Weakness of muscles or joints	YES NO UNKNOWN	
Back pain	YES NO UNKNOWN	
Difficulty walking	YES NO UNKNOWN	
NEUROLOGICAL		<input type="checkbox"/> WNL
Headaches	YES NO UNKNOWN	
Numbness/tingling sensation	YES NO UNKNOWN	
Weakness or paralysis	YES NO UNKNOWN	
Convulsions or seizures	YES NO UNKNOWN	
Change in memory/concentration	YES NO UNKNOWN	
Loss or blurring of vision	YES NO UNKNOWN	
or double vision	YES NO UNKNOWN	
Black-outs/dizziness	YES NO UNKNOWN	
Memory loss or confusion	YES NO UNKNOWN	
Other neurological problems	YES NO UNKNOWN	
PSYCHIATRIC		<input type="checkbox"/> WNL
Nervousness	YES NO UNKNOWN	
Depression	YES NO UNKNOWN	
Other	YES NO UNKNOWN	
RESPIRATORY		<input type="checkbox"/> WNL
Breathing problems/shortness of breath	YES NO UNKNOWN	
Coughing up blood	YES NO UNKNOWN	
Chronic cough	YES NO UNKNOWN	

***I have truthfully to the best of my knowledge, included all of the information requested above.**

Patient Signature

Date

***I have reviewed the information contained in this questionnaire and have reviewed the pertinent findings with the patient and/or family.**

Physician Signature

Date