The Heartbeat Clinic

Amer Suleman M.D

Please do note that our average time for a new patient appointment is 2-3 hours.

Date: _____ Patient Name: _____

DOB: _____ Age: _____ Gender: _____

Primary Care Physician: _____
How did you find us?

O Referring Physician _____
O Friend _____
O Internet
O Other: _____

1. Please INDICATE all the reasons for your visit (Check all that apply)

O Chest Pain
O Shortness of Breath
O Palpitations
O Dizziness
O Fainting (Syncope)
O Blurry Vision
O Hypertension (High blood pressure)
O Hypotension (Low blood pressure)
O Hypercholesterolemia (High cholesterol)
O Heart Failure
O Coronary Artery Disease (CAD)
O Swollen Extremities
O Postural Orthostatic Tachycardia Syndrome (POTS)
O Ehlers Danlos Syndrome (EDS)
O Gastroparesis
O Thoracic Outlet Syndrome (TOS)
O Nutcracker Syndrome
O Median Arcuate Ligament Syndrome (MALS)
O Pacemaker (PPM) or Defibrillator (ICD) Evaluation
O Implantable Loop Recorder (ILR) Evaluation
O Arrhythmia Evaluation
O Possible Testing
O Pre Surgical Evaluation
O Establish New Electrophysiologist

2. Have you had any heart disease and/or prior testing?

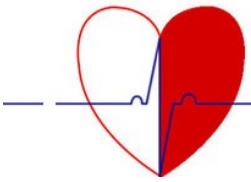
Do you have a Heart Murmur/Valve Prolapse? Yes / No

Have you ever had Rheumatic/Scarlet Fever? Yes / No

Have you ever had a Heart Attack? Yes / No

Have you ever had a Heart Cath/Angioplasty/Stent? Yes / No
If yes, what year? _____

Have you ever had Bypass Surgery? Yes / No
If yes, what year? _____



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Do you have an implantable pacemaker/defibrillator? Yes / No

Which Manufacture? _____ If yes, what year? _____

Do you have an implantable loop recorder? Yes / No

Which Manufacture? _____ If yes, what year? _____

Have you ever had a Stress Test? Yes / No

If yes, what year? _____

Have you ever had an Echocardiogram? Yes / No

If yes, what year? _____

Have you ever had a Carotid Doppler? Yes / No

If yes, what year? _____

Have you ever had a Holter Monitor (24 Heart Monitor)? Yes / No

If yes, what year? _____

List any testing you've had done (That is not above) with year: _____

_____

_____

3. Which of these risk factors for heart disease do you have?

Have you ever had High Cholesterol? Yes / No

Have you ever had High Blood Pressure? Yes / No

What does your blood pressure usually run? _____/_____

Are you a Diabetic? Yes / No

If yes, what was you last HgA1C? _____

If you are a female, do you have Female Menopause? Yes / No

Are you a Current or Recent Smoker? Yes / No

If you have quit, what year? _____

Have you taking Phen or Fen Weight Loss Medication? Yes / No

4. Do you have any blood vessels diseases?

Do you have Carotid Disease or Endarterectomy? Yes / No When?_____

Have you ever had a Stroke or TIA (Mini-Stroke)? Yes / No When?_____

Do you have an Aortic Aneurysm? Yes / No When?_____

Do you have Poor Leg Circulation? Yes / No

Do you have any Venous Thrombosis (Leg Clots)? Yes / No When?_____

Do you have any Pulmonary Embolism (Lung Clots)? Yes / No When?_____

5. Do you have dizziness/lightheadedness/syncope (passing out)?

Have you ever had a fainting or black out spell? Yes / No

If yes, describe in your own words each spell or last three spells.

1st Spell _____

_____

2nd Spell _____

_____

3rd Spell _____

_____

_____

Were any of the above spells accompanied by (Check all that apply)

O Nausea/Vomiting
O Blurry Vision
O Chest Pain
O Fast/Irregular Heart Beat
O Shortness of Breath
O Headache/Pounding
O Did they occur in a standing position?
O Did they occur in a sitting position?
O Do you get Dizziness/Lightheaded when you stand up suddenly?

6. Do you have palpitations?

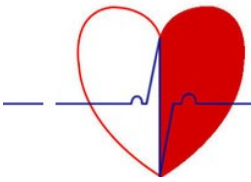
Do you ever have Palpitations (awareness of heart beat)? Yes / No

If yes, how would you classify your palpitations? (Check all that apply)

O Fast Heart Beat
O Irregular Heart Beat
O Normal Beats with Skipped or Extra Beats
O Unknown
O Other _____

What do you think makes your palpitations worsen?
(Check all that apply)

O Stress
O Exercise O Sleep
O After Eating
O Other _____



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7. What is your Past Surgical History (Operations)?
(Do not re-list any cardiac operations already listed)

Example **-** Procedure: Appendectomy Year: 1995 Location: Medical City of Dallas

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

Procedure: _____ Year: _____ Location: _____

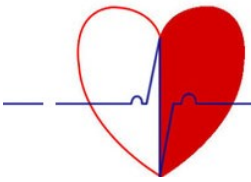
Procedure: _____ Year: _____ Location: _____

8. What are your current Medications?
(Please list all your prescription medications, non-prescription medications, vitamins, and over the counter medication including aspirin.)

NAME | DOSAGE/STRENGTH | FREQUENCY

Example – Lasix | 40 mg | 2 tabs am / 1 tab pm

1. _____ | _____ | _____/_____
2. _____ | _____ | _____/_____
3. _____ | _____ | _____/_____
4. _____ | _____ | _____/_____
5. _____ | _____ | _____/_____
6. _____ | _____ | _____/_____
7. _____ | _____ | _____/_____
8. _____ | _____ | _____/_____
9. _____ | _____ | _____/_____
10. _____ | _____ | _____/_____
11. _____ | _____ | _____/_____
12. _____ | _____ | _____/_____
13. _____ | _____ | _____/_____
14. _____ | _____ | _____/_____
15. _____ | _____ | _____/_____
16. _____ | _____ | _____/_____



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9. Are you allergic to any medication? Yes / No
(If no, skip to the next section)

Please list all medications to which you have an allergy to or adverse response to and list the reaction.

MEDICATION | REACTION
Example - Penicillin | Arm Rash

1. _____ | _____
2. _____ | _____
3. _____ | _____
4. _____ | _____
5. _____ | _____

10. What is your medical history?

Have you ever had Hepatitis/Jaundice? Yes / No If yes, what year? _____

Do you have Asthma? Yes / No If yes, what year? _____

Have you ever had a Peptic Ulcer? Yes / No If yes, what year? _____

11. What is your social history?

Marital Status: _____

Occupation: _____ Hours a week you work? _____

Do you exercise? Yes / No How many hours per week? _____ Types of activity: _____

Do you ever drink alcohol? Yes / No Drinks per week? _____ Quit Year: _____

Do you smoke? Yes / No Quantity: _____ Quit Year: _____

Do you do illicit drugs: Yes / No

Do you consume caffeine? Yes / No How much? _____

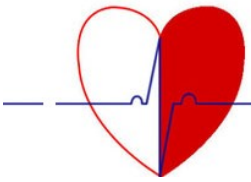
12. What is your family history? (Please fill out details of your biological relatives only)

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Illness	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
Living	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Age/s	_____	_____	_____	_____	_____	_____

Have any of your family members had a history of Heart attack, Angina, Coronary Bypass or Angioplasty **under age 55-65**? Yes / No

Have any of your family members had a history of Stroke, **under age 55 - 65**? Yes / No

Do you have any family history of Sudden Cardiac Arrest (Death)? Yes / No



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13. Recent Hospitalizations

Have you recently been hospitalized? Yes / No When?_____ Where? _____

If yes, why?_____

_____

14. Autonomic Nervous System Questionnaire (The Autonomic Nervous System plays an important role in many arrhythmias and related symptoms to help us diagnosis your symptoms)

Use the scale below to complete the list regarding your **symptoms and their frequencies.**

0 = Never 1 = 1 time a month 2 = 2-4 times a month 3 = 5-7 times a month 4 – Daily

O 0	O 1	O 2	O 3	O 4	- Fainting (Syncope)
O 0	O 1	O 2	O 3	O 4	- Dizziness/Lightheadedness (Faintness)
O 0	O 1	O 2	O 3	O 4	- Lightheadedness on standing
O 0	O 1	O 2	O 3	O 4	- Impaired memory on standing
O 0	O 1	O 2	O 3	O 4	- Impaired Memory/Confused
O 0	O 1	O 2	O 3	O 4	- Sensation of Head/Room Spinning
O 0	O 1	O 2	O 3	O 4	- Headache/Head Pounding
O 0	O 1	O 2	O 3	O 4	- Tremulousness
O 0	O 1	O 2	O 3	O 4	- Exertional Shortness of Breath
O 0	O 1	O 2	O 3	O 4	- Shortness of Breath when lying down
O 0	O 1	O 2	O 3	O 4	- Sensation of Rapid Heart Beat
O 0	O 1	O 2	O 3	O 4	- Sensation of forceful, Slow Heart Beat
O 0	O 1	O 2	O 3	O 4	- Chest Discomfort
O 0	O 1	O 2	O 3	O 4	- Excessive Sweating during day
O 0	O 1	O 2	O 3	O 4	- Excessive Sweating at night
O 0	O 1	O 2	O 3	O 4	- Clamminess of Skin
O 0	O 1	O 2	O 3	O 4	- Itching of Hands/Feet
O 0	O 1	O 2	O 3	O 4	- Trouble tolerating cold
O 0	O 1	O 2	O 3	O 4	- Trouble tolerating heat
O 0	O 1	O 2	O 3	O 4	- Bloating After Meals
O 0	O 1	O 2	O 3	O 4	- Nausea/Vomiting
O 0	O 1	O 2	O 3	O 4	- Difficultly swallowing or choking
O 0	O 1	O 2	O 3	O 4	- Saliva dribbling out of mouth
O 0	O 1	O 2	O 3	O 4	- Has food ever been stuck in your throat
O 0	O 1	O 2	O 3	O 4	- Abdominal discomfort
O 0	O 1	O 2	O 3	O 4	- Right Upper Quadrant Pain
O 0	O 1	O 2	O 3	O 4	- Constipation
O 0	O 1	O 2	O 3	O 4	- Heartburn
O 0	O 1	O 2	O 3	O 4	- Neck/Shoulder Aches
O 0	O 1	O 2	O 3	O 4	- Muscle Aches
O 0	O 1	O 2	O 3	O 4	- Joint Aches
O 0	O 1	O 2	O 3	O 4	- Pain in legs
O 0	O 1	O 2	O 3	O 4	- Leg cramps
O 0	O 1	O 2	O 3	O 4	- Blurry vision on standing
O 0	O 1	O 2	O 3	O 4	- Blurry/Dimming of Vision
O 0	O 1	O 2	O 3	O 4	- Eyes sensitive to light
O 0	O 1	O 2	O 3	O 4	- Fatigue/Feeling Weak
O 0	O 1	O 2	O 3	O 4	- Trouble falling asleep
O 0	O 1	O 2	O 3	O 4	- Difficulty maintaining sleep
O 0	O 1	O 2	O 3	O 4	- Daytime fatigue
O 0	O 1	O 2	O 3	O 4	- Anxiety
O 0	O 1	O 2	O 3	O 4	- Urinary Incontinence/Leaking
O 0	O 1	O 2	O 3	O 4	- Difficulty Emptying Bladder
O 0	O 1	O 2	O 3	O 4	- Loose/Watery Stools

15. Review of Systems

(Check all that apply)

Cancer (List Any) _____

Endocrine:

- O Low Thyroid
- O High Thyroid
- O Diabetes

Eyes:

- O Glaucoma
- O Cataracts

Lungs/Breathing:

- O Persistent Cough
- O Bronchitis
- O Emphysema
- O COPD
- O Pneumonia

Neurological:

- O Seizures/Epilepsy
- O Stroke

Abdomen:

- O Hiatus Hernia

Kidney/Bladder:

- O Renal Failure
- O Dialysis
- O Kidney Stones

Infections:

- O AIDS
- O HIV

Blood:

- O Bleeding Problems
- O Leukemia