Print Form

Date:___/_____/_____
Call Rec'd: ___:___a.m./p.m.

EISENHOWER SMILOW HEART CENTER

Interventional Atrial Fibrillation Program

Phone: (760)-834-3501 Fax: (760)-568-6470

Name:_____
First Last

Address:_____
Street Address City State Zip

Age: _____

Have you been diagnosed by a physician or cardiologist as having A-Fib?
☐ Yes ☐ No
How long have you been experiencing A-Fib symptoms:_____

Who is your physician or cardiologist? _____ **Date last seen:**

- **Primary Care Physician**_____ _____/_____/____
- **Cardiologist**_____ _____/_____/____

Do you have a history of heart valve disease?	☐ Yes	☐ No
Have you had previous open-heart surgery?	☐Yes	☐ No
Have you received treatment for A-Fib in the past?	☐ Yes	☐ No
- **Have you had a cardioversion?**	☐ Yes	☐ No
- **Have you had an ablation?**	☐ Yes	☐ No
- **Do you take medication for A-Fib?**	☐ Yes	☐ No

Medications:

- **Coumadin (Warfarin)**	☐ Yes	☐ No
- **Aspirin**	☐ Yes	☐ No
- **Amiodarone**	☐ Yes	☐ No
- **Digitalis**	☐ Yes	☐ No
- **Beta Blocker**	☐ Yes	☐ No
- **Plavix**	☐ Yes	☐ No
- **Thyroid Supplementation**	☐ Yes	☐ No

Who is your insurance carrier?

What is the best way to contact you?

Call ended: ___:___ a.m./p.m.