Heart Rhythm Clinic

SHYAM K. NAIR, MD, FACC

NAME: **AGE:**

		YES	NO	How long
Do you have	Hypertension(High Blood Pr)			
	Diabetes			
	High Cholesterol			
	Stroke			
	Liver problems			
	Kidney problems			
Other medical problems_____				

Have you had	Heart attacks	Y N	When	
	Angiogram/plastty	Y N	When	
	Open heart surgery	Y N	When	
	Pacemaker/ICD implantation	Y N	When	
	Electrophysiology Study	Y N	When	

	Yes	No
Do you have chest pains?		
Do you get short of breath?		

How far can you walk before you get short of breath?

	1	>1
How many pillow/s do you use at night?		
Do you wake up at night because you cannot breath?		
Do you feel your heart beat funny or have palpitations?		
Do you get swelling in your feet?		
Do you get pain in your legs when you walk?		
How far can you walk before you get pain?		
Do you cough on a regular basis?		

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Have you had any recent fainting spells? Y N

Do you have any seizure disorders/Epilepsy? Y N

Have you had any recent numbness or weakness? Y N

List your allergies:_____

_____

Please list all the operations you have had and the year:_____

_____

Do any of your family members suffer from:

Diabetes Heart diseases Other

Hypertension Sudden cardiac death Cancer

Are you ( ) Single ( ) Married ( ) Widowed ( ) Divorced

If so for how long?

Have you ever smoked? If so how many per day?_____ For how long?_____

When did you stop smoking?

How much alcohol do you take?

Have you ever used illicit drugs? Y N If so when?_____

What Kind?

What kind of work do you do?_____

Are you retired? Y N If so when?_____

What kind of work did you do before you retired?_____

Are you on disability? If so what kind of disability do you have?_____

What kind of work does your spouse do?_____

CURRENT MEDICATIONS

Name: _____ **D.O.B:** _____ **Date:** _____

Medication	Dosage	Directions