Charleston
Heart Specialists
TRIDENT HEALTH

9221 University Blvd., Ste. 102, Charleston, SC 29406
Phone: 843.576.0700 Fax: 843.576.0701

Darren S. Sidney, M.D.

Patient Information Form

Patient Name ____________________________

Date of Visit: ________________

Date of Birth: _____/_____/_____ Age: ________ Sex: ☐ Male ☐ Female

Referring Physician / Provider(s): ____

Primary Care Physician / Provider: ____

Reason for Visit: ____

Past Cardiac History (Check all that apply):

☐ Coronary artery disease (blockage in arteries)

☐ Congestive heart failure (last hospital admission: ______________________________)

☐ Angina / chest pain (how often: ______________________ how long ______________________)

☐ Heart attack (dates: ____)

☐ Angioplasty / stenting (dates: ____)

☐ Bypass surgery (dates: ______________________________ , number of bypasses: _______)

☐ Valve surgery (if yes, what type: ____)

☐ Peripheral vascular disease ____

☐ Stroke or mini-stroke (TIA) ____

☐ Sudden cardiac arrest ____

☐ Syncope or passing out spells (# of episodes: __________ last episode: ______________________)

☐ Pacemaker (date: ________________ type: ____)

☐ ICD or implantable defibrillator (dates: ________________ type: ______________________________)

☐ Atrial fibrillation and/or flutter ____

☐ Other abnormal heart rhythm: ____

☐ Prior catheter ablation procedure (dates: ______________ type: ______________________________)

Reviewer initials ________

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Past Surgical History (Check all that apply and add dates):

☐ Tonsillectomy: ______________________________ ☐ Appendectomy: ______________________________
☐ Gall Bladder: ______________________________ ☐ Hysterectomy: ______________________________
☐ Hernia Repair: ______________________________ ☐ Hemorrhoids: ______________________________

List other surgeries (with dates): ______________________________
____
____

Family History (Check all that apply):

Do your immediate family members have a history of:

☐ Heart attack ☐ Bypass surgery or angioplasty ☐ Congestive heart failure
☐ Sudden death ☐ Atrial Fibrillation ☐ Stroke
☐ Diabetes ☐ High blood pressure ☐ High cholesterol
☐ Cancer (type: ______________________________)

Social History (Check all that apply):

☐ Married ☐ Widowed ☐ Single ☐ Divorced
☐ Retired (Occupation: ______________________________)

Smoking History:

☐ Active smoker (packs per day? ___________ how long? ______________)
☐ Former smoker (packs per day? ___________when quit? ______________)

Alcohol History:

☐ None ☐ Yes (drinks per day? _________ how long? ______________ what type? ___________)

Medication Allergies: ______________________________

Other Allergies: ______________________________

Current Medications (Please list all medications with doses and frequency):

____
____
____
____

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Symptoms Review (Check all that apply – recent symptoms please):

Constitutional

☐ fever ☐ chills ☐ night sweats
☐ unexplained weight loss ☐ loss of appetite ☐ insomnia

Eyes, Ears, Nose, Throat

☐ visual disturbance ☐ eye discharge ☐ eye redness
☐ decreased hearing ☐ ear discomfort ☐ ringing in ears
☐ nasal congestion ☐ sinus infection ☐ nose bleeds
☐ sore throat ☐ difficulty swallowing ☐ other: ____________________

Cardiovascular

☐ chest pain ☐ shortness of breath with exertion / activity
☐ shortness of breath lying flat ☐ waking at night with shortness of breath
☐ lower extremity swelling ☐ calf or buttock pain with walking
☐ other: ____

Lungs

☐ shortness of breath ☐ wheeze ☐ cough
☐ coughing blood ☐ sputum production
☐ other: ____

GI

☐ nausea ☐ vomiting ☐ diarrhea
☐ constipation ☐ dark sticky stools ☐ bright red blood per rectum
☐ other: ____

Urinary

☐ pain with urination ☐ blood in urine
☐ increased frequency of urination ☐ urgency to urinate
☐ frequesnt urination at night (____ times per night) ☐ incontinence
☐ other: ____

Neurologic

☐ headache ☐ seizure ☐ tingling
☐ numbness ☐ weakness, location ______________ ☐ back pain
☐ other: ____

Skin

☐ rash ☐ skin cancer ☐ other: ____________________

Psychiatric

☐ depression ☐ anxiety ☐ other: ____________________

Form completed by ☐ Patient ☐ Other Name/Relationship ______________________________

Physician Signature/Initials ______________________________ Date __________ Time ________ AM / PM

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Atrial Fibrillation (AF) History

Date of first symptoms: ______________________ Date of first diagnosis: ______________________

Frequency of AF: ☐ daily ☐ 2-4x/week ☐ 2-4x/month ☐ 2-6x/year

Duration of AF: ☐ < 1 min ☐ < 10 min ☐ < 2 hrs ☐ 2-12 hrs ☐ > 12 hrs ☐ > 2 days

Symptoms with AF (Check all that apply):

☐ palpitations ☐ heart racing ☐ irregular heart beat ☐ dizziness/lightheadedness
☐ fatigue ☐ chest pain ☐ passing out spells

Medications tried / failed (Check all that apply):

☐ amiodarone® ☐ flecainide (Tambocor®) ☐ propafenone (Rythmol®)
☐ sotalol (Betapace®) ☐ dofetilide (Tikosyn®) ☐ digoxin (Lanoxin®)
☐ metoprolol (Toprol®, Lopressor®) ☐ atenolol (Tenormin®) ☐ other: ____________________
☐ diltiazem (Cartia®, Cardizem®) ☐ verapamil ☐ other: ____________________

Have you ever needed to be hospitalized for AF?

☐ No ☐ Yes (dates: ____)

Have you ever needed cardioversion (electrical shock)?

☐ No ☐ Yes (dates: ____)

Does anything specific trigger your AF episodes? ______________________________

Other Past Medical History (Check all that apply):

☐ High blood pressure ☐ High cholesterol ☐ Diabetes
☐ Reflux/heartburn ☐ Thyroid disorder ☐ Anemia
☐ Asthma ☐ COPD / Emphysema ☐ Arthritis
☐ Ulcers ☐ GI bleeding ☐ Frequent falls
☐ Cancer (type(s): ____)

List other active medical problems: ______________________________________

____

____

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