CARDIAC EP CONSULTANTS, S.C.

PATIENT RETURN VISIT INFORMATION

NAME ____

ARE YOU HAVING ANY OF THE FOLLOWING?

PALPITATIONS	YES / NO
EPISODES OF PASSING OUT	YES / NO
LIGHTHEADEDNESS OR DIZZINESS	YES / NO
SHORTNESS OF BREATH WITH DAILY ACTIVITIES	YES / NO
WHEEZING	YES / NO
WAKING UP AT NIGHT SHORT OF BREATH	YES / NO
SWELLING IN LEGS	YES / NO
CHEST PAIN	YES / NO
COUGHING	YES / NO
BLEEDING PROBLEMS (SKIN, STOOL, OR URINE)	YES / NO
VOMITING/ABDOMINAL PAIN/ DIARRHEA	YES / NO
DIFFICULTY URINATING	YES / NO
PROBLEMS WITH DEVICE SITE	YES / NO
SHOCKS FROM YOUR DEFIBRILLATOR	YES / NO

CHANGES IN LIVING SITUATION?	YES / NO
ARE YOU A CURRENT SMOKER?	YES / NO

NEW MEDICATIONS?	YES / NO
NEW MEDICATION ALLERGIES?	YES / NO

If YES, Please List:

NEW MEDICAL PROBLEMS / RECENT SURGERIES?	YES / NO

If YES, Please List:

Circle if you have had any of the following since your last visit:

ECHO ANGIOGRAM EVENT MONITOR STRESS TEST CHEST X-RAY

If Yes, where & when was this done: --

Name & Tel # of ordering Physician : --

Pharmacy Name: --- Tel: -----------------------------

Location: -- Fax: -----------------------------

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