HRI OF AZ THE HEART RHYTHM INSTITUTE OF ARIZONA

Health History Update

Please Check YES or NO if any of these symptoms are currently present. Date: _____
NOTE: Please do not leave any blanks

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
Cardiac:			**Respiratory:**			**Psychiatric:**		
Chest Pains			Snoring			Depression		
Palpitations			Hemoptysis (Coughing up blood)			Hallucinations		
Diaphoresis (Excessive sweating)			Dyspnea (shortness of breath)			**Hematologic:**		
Syncope (fainting)			**Gastrointestinal:**			Acute Anemia		
Orthopnea (Difficulty breathing laying down)			Nausea			Thrombocytopenia (low blood platelet count)		
PND (breathing disorder related to CHF)			Reflux			**Endocrine:**		
Vascular:			Bleeding			Goiter (enlarged thyroid)		
Claudication (Pain or limping in legs)			**Genitourinary:**			Tremors		
Edema or Swelling			Hematuria (Blood in urine)			**Derm:**		
Constitutional:			Frequent urination at night (>2 times/night)			Rash		
Weight gain			**Neurological:**			Skin Sores		
Weight loss			Dizziness			**Musculoskeletal:**		
Fever			Memory loss			Joint Pain		
HEENT: (Head, Ears, Nose & Throat)			Seizures			Myalgia (muscle pain)		
Visual Changes			**Reproductive:**					
Hearing loss			HX of oral contraception (Birth Control Pills)					

Patient Name: _____
Date of Birth: _____ Height: _____ Weight: _____

(Please see and complete page 2)

Please list any medication changes *SINCE YOUR LAST VISIT*:

Name:	Dosage/Frequency:	Name:	Dosage/Frequency:
(None)			

Have you been admitted to the hospital *SINCE YOUR LAST VISIT?*

- **No**
- **Yes**
  - **If yes, when:** _____
  - **Which hospital?** _____
  - **For what reason?**

_____

_____

_____

Pharmacy Information:

Local Pharmacy Name: _____

Address: _____

Phone: _____

Mail-Order Pharmacy Name: _____

Address: _____

Phone: _____

Patient Name: _____**Date of Birth**: _____