

City Heart Week / Arrhythmia Awareness Week 2009

Palpitation Assessment – Sheet 1

Name: _____

Address: _____

DOB: ____: ____: ____

G.P.: _____ Address: _____

Do you have Private Health Insurance: Yes / No

How did you hear about City Heart Week:

Posters Flyer TV/Radio Advert Web site Other

ALLERGIES Yes No If YES – specify: _____

Do you suffer, or have you suffered from any of the following?

Diabetes Hypertension Heart attack Epilepsy
Stroke Asthma Raised cholesterol

Comments: (and any other illnesses/operations)

Alcohol units/week (One unit equates to half a pint of beer/lager, a small glass of wine, or single measure of spirits):

Non drinker 1-7u 8-14u 15-21u 22-28u 28-35u 35+

Do you currently smoke or have you ever smoked?

Never smoked Used to smoke Currently Smoke

Caffeine intake: _____ cups or glasses/day **Illicit drugs:** Yes No

CURRENT MEDICATION (over the counter or prescribed, include herbal remedies)