Washington Heart Rhythm Associates, LLC
Pirooz Mofrad MD, FACC, FHRS
10230 New Hampshire Avenue, Suite 204
Silver Spring, MD 20903
Telephone: 301-408-7890 Fax: 301-408-7892

NEW CLINIC PATIENT QUESTIONNAIRE

Name (Last, First)	**Birthdate**	**Age**	**Sex** M F
Appointment Date	**Clinic Physician**		

Did another physician refer you? ☐ **Yes** ☐ **No** ☐ **Self-Referral**

Referring MD Name_____
Street Address _____
City, State, Zip Code _____
Phone ( ) _____ Fax ( ) _____

If you have a primary physician, other than the referring physician, please complete so we can send them a report of your office visit

Primary Care MD Name _____
Street Address _____
City, State, Zip Code _____
Phone ( ) _____ Fax ( ) _____

Would you like this clinic's visit information sent to any physician other than those listed above? ☐ **Yes** ☐ **No**

MD Name _____
Street Address _____
City, State, Zip Code _____
Phone ( ) _____ Fax ( ) _____

What is the reason for your clinic appointment today?

_____
_____
_____
_____
_____
_____

Past Medical History

Please indicate if you have ever been **diagnosed** with any of the following conditions. If Yes, please give an explanation.

SYSTEM	YES	NO	PATIENT COMMENTS
CARDIOVASCULAR			
Atrial Fibrillation	☐	☐	
Blood Clotting Disorder	☐	☐	
Carotid Artery Disorder	☐	☐	
Congestive Heart Failure	☐	☐	
Elevated Cholesterol	☐	☐	
Heart Murmur	☐	☐	
Heart Attack/Angina	☐	☐	
Heart Surgery/Angioplasty	☐	☐	
High Blood Pressure	☐	☐	
Prosthetic/Artificial Heart Valve	☐	☐	
Blockage of Arm/Leg Vessels	☐	☐	
GASTROINTESTINAL/ GENITOURINARY/ RESPIRATORY			
Stomach Ulcers	☐	☐	
Liver Disease/Hepatitis	☐	☐	
Kidney/Bladder Disease	☐	☐	
Lung Disease	☐	☐	
Tuberculosis	☐	☐	
OTHER			
Alcohol Dependency	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Drug Abuse	☐	☐	
Immune System Disorder	☐	☐	
Thyroid Disease	☐	☐	
Toxic Exposure	☐	☐	
Sexually Transmitted Disease	☐	☐	

OTHER PAST MEDICAL HISTORY (Please list all medical conditions not mentioned above)_____

_____

_____

_____

_____

_____

PREVIOUS OPERATIONS/HOSPITALIZATIONS:

Date	Hospital	Problem/Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS (Please list all medications, i.e. over-counter medications and herbal meds)

Medications	Dosage	Number Taken Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergy History

Have you ever had an allergic reaction to any medication? ☐ Yes ☐ No If yes, please list medication and reaction.

_____

_____

Social History

Birthplace: _____ Highest Grade completed in School: _____

Current Occupation: _____

Relationship/Marital status: _____

Have you ever smoked cigarettes: ☐Yes ☐No

If yes, how much do you currently smoke per day? ☐ ½ pack ☐1 pack ☐2 packs ☐> 2 packs

If you previously smoked, how long ago did you quit? ☐ 1 year ☐1-5 years ☐> 5 years

How many years did you smoke? _____

Have you had significant exposure to: Pesticides? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No Type_____ How often/much? _____

Do you exercise? ☐Yes ☐No If yes, how much? ☐Rarely ☐Occasionally ☐>3 times/week

Dietary Restrictions? _____

Family History:

Family Member	*Age (or age at death)*	*Medical Problems*
Grandparents	_____	_____
	_____	_____
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____

Review of Systems

Have you experienced any of the following symptoms? Please circle Yes, No, or Unknown. If Yes, please give an explanation.

SYSTEM	Patient: Circle Response			Physician / Patient Comments
ALLERGY/IMMUNOLOGY				❑ **WNL**
Low resistance to infection	YES	NO	UNKNOWN	
Environmental allergies	YES	NO	UNKNOWN	
CARDIOVASCULAR				❑ **WNL**
Chest pain or angina	YES	NO	UNKNOWN	
Irregular heart rhythm	YES	NO	UNKNOWN	
Swelling of the feet, ankles, hands	YES	NO	UNKNOWN	
CONSTITUTIONAL				❑ **WNL**
Good general health lately	YES	NO	UNKNOWN	
Recent weight changes	YES	NO	UNKNOWN	
Extreme fatigue	YES	NO	UNKNOWN	
Frequent nausea, vomiting	YES	NO	UNKNOWN	
Difficulty sleeping	YES	NO	UNKNOWN	
EARS, NOSE, MOUTH, THROAT				❑ **WNL**
Change in hearing	YES	NO	UNKNOWN	
Ringing in the ears	YES	NO	UNKNOWN	
Recent nose bleeds	YES	NO	UNKNOWN	
Chronic sinus problems	YES	NO	UNKNOWN	
Voice changes	YES	NO	UNKNOWN	
EYES				❑ **WNL**
Wear glasses, contact lenses	YES	NO	UNKNOWN	
Change in vision	YES	NO	UNKNOWN	
Glaucoma	YES	NO	UNKNOWN	
ENDOCRINE				❑ **WNL**
Heat or cold intolerance	YES	NO	UNKNOWN	
Excess thirst or urination	YES	NO	UNKNOWN	
GASTROINTESTINAL				❑ **WNL**
Change in appetite	YES	NO	UNKNOWN	
Severe heart burn	YES	NO	UNKNOWN	
Vomiting blood	YES	NO	UNKNOWN	
Frequent diarrhea	YES	NO	UNKNOWN	
Constipation	YES	NO	UNKNOWN	
Black or bloody stools	YES	NO	UNKNOWN	
Abdominal pain	YES	NO	UNKNOWN	

SYSTEM	Patient: Circle Response			Physician / Patient Comments
GENITOURINARY				❑ WNL
Blood in urine	YES	NO	UNKNOWN	
Burning with urination	YES	NO	UNKNOWN	
Difficult/frequent urination	YES	NO	UNKNOWN	
Lack of bladder control	YES	NO	UNKNOWN	
Sexually transmitted disease	YES	NO	UNKNOWN	
Change in sexual function	YES	NO	UNKNOWN	
HEMATOLOGY/LYMPHATIC				❑ WNL
Easy bruising	YES	NO	UNKNOWN	
Frequent bleeding	YES	NO	UNKNOWN	
Enlarged lymph nodes	YES	NO	UNKNOWN	
INTEGUMENTARY SKIN & BREASTS				❑ WNL
Unusual or prolonged rashes	YES	NO	UNKNOWN	
Breast pain or lump	YES	NO	UNKNOWN	
Change in hair or nails	YES	NO	UNKNOWN	
MUSCULOSKELETAL				❑ WNL
Joint/muscle stiffness or pain	YES	NO	UNKNOWN	
Weakness of muscles or joints	YES	NO	UNKNOWN	
Back pain	YES	NO	UNKNOWN	
Difficulty walking	YES	NO	UNKNOWN	
NEUROLOGICAL				❑ WNL
Headaches	YES	NO	UNKNOWN	
Numbness/tingling sensation	YES	NO	UNKNOWN	
Weakness or paralysis	YES	NO	UNKNOWN	
Convulsions or seizures	YES	NO	UNKNOWN	
Change in memory/concentration	YES	NO	UNKNOWN	
Loss or blurring of vision	YES	NO	UNKNOWN	
or double vision	YES	NO	UNKNOWN	
Black-outs/dizziness	YES	NO	UNKNOWN	
Memory loss or confusion	YES	NO	UNKNOWN	
Other neurological problems	YES	NO	UNKNOWN	
PSYCHIATRIC				❑ WNL
Nervousness	YES	NO	UNKNOWN	
Depression	YES	NO	UNKNOWN	
Other	YES	NO	UNKNOWN	
RESPIRATORY				❑ WNL
Breathing problems/shortness of breath	YES	NO	UNKNOWN	
Coughing up blood	YES	NO	UNKNOWN	
Chronic cough	YES	NO	UNKNOWN	

***I have truthfully to the best of my knowledge, included all of the information requested above.**

_____ _____

Patient Signature **Date**

***I have reviewed the information contained in this questionnaire and have reviewed the pertinent findings with the patient and/or family.**

_____ _____

Physician Signature **Date**