

ARRHYTHMIA – ATRIAL FIBRILLATION

CLIENT NAME: _____
Submit the Impaired Risk Questionnaire with this form

1. List the date when first diagnosed: _____
2. Is the atrial fibrillation/flutter:
 chronic (permanent)
 paroxysmal (intermittent)
3. Are there any symptoms with the irregular heart beat?
 black-out dizziness (light-headedness)/faint feeling
 palpitations chest discomfort
4. Have any of the following tests been done?
(If so, please give date and results:
 ECG _____
 stress test _____
 echocardiogram _____
 Holter monitor _____
5. The cause of the atrial fibrillation/flutter is due to:
 coronary heart disease alcohol
 thyroid disease unknown or other
 mitral valve disease cardiomyopathy
6. Is client on any medications?: *(accurate spelling, dosage, reason for meds)*
7. Are there are any other health issues?