BAY HEART & VASCULAR

ELECTROPHYSIOLOGY INTAKE FORM

Patient Name: ________________________________ DOB: ___________ Age: ____ Date: _________

Insurance: __________________________________ Referring Provider: ________________________

Has the patient seen Dr. Mahmud before? ☐ Yes ☐ No

Chief Complaint: ____

____

____

____

Pulse _______ BP: Rt. _____ Lt: _____ Orthostatic________ R ____ Wt. ____ (+/-) Ht. ____ BMI ____

Nutritional Counseling Offered? Y/N Are you in pain? Y/N Location: ____________ Pain Scale 0-10___

Able to perform ADL's Y/N Are you being abused or neglected? Y/N

PROVIDER NOTES/PHYSICAL EXAM

History: Palpitations ____ Syncope ____ Near Syncope _____ Fatigue _____

Dyspnea _____ Orthopnea ____ PND _____

PMH: CAD ____ MI ____ CHF _____ HTN _____ DM _____ Stroke ____

ROS: Syncope ____ Near Syncope _____ Palpitations ____ Dyspnea ____

SH: Smoking _____ ETOH _____ Recreational Drugs __________

FH: SCD _____ CVA _____ Arrhythmias _____

PE: ____

Pre-Procedure Orders: ____________________________

____

Stop taking the following medications _________________

____

Recommendations: ____________________________

____

____

____

Return to Clinic: ____

Level of Care: **E** **C** **New Pt.** **1** **2** **3** **4** **5**

Patient Understanding ☐

____ ____

Nursing Date / Time Physician Date / Time