Atrial Fibrillation Clinic
100 High Street
Buffalo, N.Y. 14203

NEW PATIENT PACKET

Please bring this packet along with the following checklist to your first appointment:

- CURRENT MEDICATIONS
- INUSRANCE CARD
- RECENT LAB WORK, CARDIAC TESTING, & HOSPITAL RECORDS

Your appointment is on ____with Maggie McLaughlin FNP.

We are located on the 2nd floor "B" building.

At Buffalo General Hospital

Please arrive 15 minutes prior to your appointment time.

If you have any questions, please call (716) 859-2342

GREAT LAKES CARDIOVASCULAR

New Patient Medical Review Form
The Atrial Fibrillation Center

Name:______________________________ **DOB**:____________________

Primary Physician: ______________________ **Referring Physician:** ____________________

Cardiologists:____

Specialists: ____

Please take a moment to help us better understand your symptoms and medical information.
Kindly place a check in each appropriate box.

Reason for Consult:____

Allergies: ❑ Latex ❑ Iodine ❑ IV Dye ❑ Seafood ❑ Drug:______________________

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Current Medications (please write medications or attach separate list):____________________

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Have you been diagnosed with Atrial Fibrillation? ❑ Yes ❑ No Estimated Date?____________________

Have you tried medications for Atrial Fibrillation? ❑ Yes ❑ No Which ones?____________________

Have you had an Ablation? ❑ Yes ❑ No Estimated Date?____________________

Have you had a Cardioversion? ❑ Yes ❑ No Estimated Date?____________________

Do you have a Pacemaker/Defibrillator? ❑ Yes ❑ No Make/Model?____________________

Have you had a sleep study? ❑ Yes ❑ No Estimated Date?____________________

Past Medical History

High Blood Pressure	❑	Heart Failure	❑	Kidney Disease	❑
Coronary Artery Disease	❑	Stroke	❑	Bleeding Disorder	❑
Irregular Heart Rhythm	❑	TIA	❑	Anemia	❑
Heart Murmur	❑	Syncope	❑	COPD	❑
High Cholesterol	❑	Sleep Apnea	❑	Asthma	❑
Cardiomyopathy	❑	Diabetes	❑	Emphysema	❑
Heart Attack	❑	Thyroid Disease	❑		

Family Members with Cardiac Disease or Sudden Cardiac Death?______________________________

Past Surgical History

Angioplasty	❑	Appendix	❑	Hysterectomy	❑
Bypass	❑	Gallbladder	❑	Other	❑ ____________________
Appendix	❑	Tonsils	❑		____________________
Heart Valve	❑	Hernia	❑		____________________
EP study	❑	Joint Replacement	❑		____________________
					____________________
					____________________

Do you experience any of the following?

Fatigue	❑ Yes ❑ No	Headache	❑ Yes ❑ No
Weight Change	❑ Yes ❑ No	Palpitations/ Fluttering In Chest	❑ Yes ❑ No
Mood Change	❑ Yes ❑ No	Cough	❑ Yes ❑ No
Change In Vision	❑ Yes ❑ No	Coughing up Blood	❑ Yes ❑ No
Dizziness	❑ Yes ❑ No	Coughing up Pink Sputum	❑ Yes ❑ No
Shortness of Breath at Rest	❑ Yes ❑ No	Abdominal Pain	❑ Yes ❑ No
Shortness of Breath with Activity	❑ Yes ❑ No	Lack of Appetite	❑ Yes ❑ No
Shortness of Breath Lying Down	❑ Yes ❑ No	Nausea	❑ Yes ❑ No
Shortness of Breath at Night	❑ Yes ❑ No	Rectal Bleeding	❑ Yes ❑ No
Coughing at Night	❑ Yes ❑ No	Hair Loss	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Heat/Cold Intolerance	❑ Yes ❑ No
Swelling of Legs	❑ Yes ❑ No	Tremors	❑ Yes ❑ No
Fainting with Passing Out	❑ Yes ❑ No	Excessive Bleeding	❑ Yes ❑ No
Lightheaded	❑ Yes ❑ No		

Have you had recent cardiac testing?

Echo ❑ EKG ❑ Stress test ❑ EP study ❑ MUGA ❑ Tilt table ❑

Carotid Doppler ❑ Chest X-ray ❑ Other ❑ ____

Any pertinent information/concerns that were not captured above? ____

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*Please notify staff at check in of any changes to: pharmacy, insurance, primary doctor/cardiologist, or personal contact information *

- Thank you from the Atrial Fibrillation Staff

GREAT LAKES CARDIOVASCULAR

Name: ____ DOB:______________________

Address:____

Phone Number:_____________________________ Cell Number:________________________________

Email:____

Emergency Contact:____ Relationship:________________________

Phone Number:_____________________________

Primary Insurance Name:____

Policy Holder:____

Policy Number:_____________________________________ Group Number:__________________________

Secondary Insurance Name: ____

Policy Holder: ____

Policy Number:_____________________________________ Group Number:__________________________

Pharmacy Name: _______________________________________ Phone Number: ___________________________

Address: ____