|  |  |
| --- | --- |
|  |  Patient ID #       |
|  |  |

## Cardiac Screening form Please answer the following questions

## Patient Information Section 1

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |      |       |       | DOB: |        |
|  | Last | First | M.I. |  |  |

Social Security #:       AHCCCS (Medicaid) ID #:

Other Insurance information if not AHCCCS?

## Health Information Section 2

 Personal History Family History?

1. An abnormal EKG Yes [ ]  No [ ]  Yes [ ]  No [ ]

2. Long QT Syndrome Yes [ ]  No [ ]  Yes [ ]  No [ ]

3. Cardiac Conduction Defects Yes [ ]  No [ ]  Yes [ ]  No [ ]  If yes, when?

4. Arrythmias

 Irregular heart rate Yes [ ]  No [ ]  Yes [ ]  No [ ]

 Fast heart rate – tachycardia Yes [ ]  No [ ]  Yes [ ]  No [ ]

 Slow heart rate – bradycardia Yes [ ]  No [ ]  Yes [ ]  No [ ]

 Skipped beat Yes [ ]  No [ ]  Yes [ ]  No [ ]

 Heart palpitations Yes [ ]  No [ ]  Yes [ ]  No [ ]

5. Syncope Episodes (unexplained fainting spells) Yes [ ]  No [ ]  Yes [ ]  No [ ]

6. Blacking Out Yes [ ]  No [ ]  Yes [ ]  No [ ]

7. Seizures Yes [ ]  No [ ]  Yes [ ]  No [ ]

8. Palpitations Yes [ ]  No [ ]  Yes [ ]  No [ ]

9. Dizziness Yes [ ]  No [ ]  Yes [ ]  No [ ]

10. Lightheadedness Yes [ ]  No [ ]  Yes [ ]  No [ ]

11. Other relevant Cardiac Disease

 Structural Heart Disease – Any history of Heart Disease? Yes [ ]  No [ ]  Yes [ ]  No [ ]

If yes, please explain:

12. Pacemakers Yes [ ]  No [ ]  Yes [ ]  No [ ]

13. Members of the family who have had Sudden Death/Unexplained Death at a young age (< age 50)

Please explain:

## Personal History of Electrolyte Disturbances Section 3

1. Have you ever had Hypokalemia? Yes [ ]  No [ ]
2. Have you ever had Hypomagnesemia? Yes [ ]  No [ ]
3. Do you take any medications that cause electrolyte disturbances?

Diuretics (Lasix)? Yes [ ]  No [ ]

Laxatives – on a regular basis? Yes [ ]  No [ ]

Chemotherapy drugs (Cisplatin)? Yes [ ]  No [ ]

Antifungal (Amphotericin B)? Yes [ ]  No [ ]

Coricosteroids (Hydrocortisone)? Yes [ ]  No [ ]

If yes, what?

## Medication Use Section 4

List **ALL** prescription medications you are currently taking:

What medications are you taking, or have you taken in the past to prolong cardiac QTC interval?

**Additional CNS Depressant Medications**:

1. Do you use Alcohol? Yes [ ]  No [ ]

If yes, how often and how much?

2. Do you take any Benzodiazepines? Yes [ ]  No [ ]

If yes, what kind, how much and how often?

3. Do you take Barbiturates? Yes [ ]  No [ ]

If yes, what kind, how much and how often?

4. Personal use of Illicit Drugs; list all illicit/street drugs you are using:

5. Over the Counter Medications; List all the over the counter medications (especially Ephedra) you are currently taking?

6. Personal Use of Prescribed Narcotics; List all prescribed narcotics you are currently taking?

**Prior history of Methadone Metabolism abnormalities – poor or rapid Methadone Metabolism:**

1. Have you ever had a peak and trough test done to assess Methadone Metabolism? Yes [ ]  No [ ]

 If yes, what were the results?

2. Have you ever had a Methadone dose above 150mg? Yes [ ]  No [ ]

**Medically Frail/Multiple Medical Conditions;** Please explain:

**Comments:**

## Client Signature Section 5

I certify that my answers are true and complete to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** |       |
| **Print Name:** |        |  |  |

## Staff Review – Office use only Section 6

**Form checked and reviewed by:**

Name:       Position:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_