|  |  |
| --- | --- |
|  | 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: \_\_\_\_\_\_\_\_\_\_\_