



**atrialfibrillationassociation**

[www.afa.org.uk](http://www.afa.org.uk)

Providing information support and access to established,  
new or innovative treatments for Atrial Fibrillation

# Atrial Fibrillation Checklist



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# Introduction

If you have been diagnosed as suffering from **Atrial Fibrillation** or **Atrial Flutter**, it would be very useful to your doctor if you would fill out this checklist which is designed to provide your doctor with some of the information that may be needed to choose the best treatment for you. Atrial Fibrillation and Atrial Flutter are common heart rhythm disturbances which may produce symptoms such as palpitations, breathlessness, chest pain and tiredness. In some patients the rhythm disturbances may result in complications such as heart failure (sluggish beating of the heart) or sometimes stroke. There are many different and important treatments for atrial fibrillation and atrial flutter which are very effective, preventing the symptoms and the complications of the condition. The right choice of treatment depends in part on accurate information from the patient.

This checklist is intended to help to provide that important information to your doctor. It would be very useful to fill this out before visiting your doctor. Do not worry if there are any technical terms you do not understand – just put a question mark (?)

<b>What is your name?</b>	.....		
<b>Date of Birth:</b>	..... / ..... / .....		
<b>What is your gender?</b>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
	<b>Yes</b>	<b>No</b>	<b>When (date)</b>
<b>Do you suffer from any of these symptoms?</b>			
Palpitations lasting more than 2 seconds	<input type="checkbox"/>	<input type="checkbox"/>	.....
Irregular	<input type="checkbox"/>	<input type="checkbox"/>	.....
Fast	<input type="checkbox"/>	<input type="checkbox"/>	.....
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	.....
With palpitations	<input type="checkbox"/>	<input type="checkbox"/>	.....
On exercise	<input type="checkbox"/>	<input type="checkbox"/>	.....
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	.....
With palpitations	<input type="checkbox"/>	<input type="checkbox"/>	.....
On exercise	<input type="checkbox"/>	<input type="checkbox"/>	.....
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	.....
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Have you had any of these medical conditions or procedures?</b>			
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	.....
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	.....
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	.....
Thyroid disturbances	<input type="checkbox"/>	<input type="checkbox"/>	.....
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>	.....
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	.....
Electrical shock treatment for your heart	<input type="checkbox"/>	<input type="checkbox"/>	.....
Ablation treatment	<input type="checkbox"/>	<input type="checkbox"/>	.....
Pacemaker implantation	<input type="checkbox"/>	<input type="checkbox"/>	.....
ICD implantation	<input type="checkbox"/>	<input type="checkbox"/>	.....

**Have you been given a definite diagnosis of:**

Atrial Fibrillation?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Atrial Flutter?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Both?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....

**Is your rhythm problem...**

Occuring as attacks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Present at all time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....

**Have you been treated with any of these medicines?**

Sotalol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Flecainide	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Dronedarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Propafenone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Amiodarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Digoxin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Beta blocker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Calcium blocker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Warfarin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Dabigatran	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....
Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Since When: .....

**Are you currently being treated with any of these medications?**

Sotalol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Flecainide	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dronedarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Propafenone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Amiodarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Digoxin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beta blocker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Calcium blocker	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Warfarin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dabigatran	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Have you seen another doctor about this condition?**

			When (date)
GP / Family doctor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Casualty doctor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Hospital doctor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Cardiologist	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Rhythm doctor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....

**Have you had any of the following tests?**

**If you have any results at home, please bring them to the clinic**

			When (date)
Resting ECG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Exercise ECG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Event ECG monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Implantable ECG monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Echo scan of the heart	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Thyroid function blood test	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Other Blood tests	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....

**Do you have a copy of your ECG?**

**If you do please bring it to the clinic**

			When (date)
When normal	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
When rhythm abnormality is present	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....

**ECG** = electrical tracing of your heart beat

**Beta blockers** = propranolol, atenolol, metoprolol, bisoprolol and other drugs ending "olol"

**Calcium Blockers** = verapamil or diltiazem

**TIA** = transient ischemic attacks



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Affiliated to Arrhythmia Alliance  
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Please remember these are general guidelines and individuals should always discuss their condition with their own doctor.

