



HEART HEALTH HISTORY

Print this list of questions, complete the answers and take them with you to discuss with your healthcare team.

1. My palpitations started suddenly.

Yes

No

2. My palpitations feel like skipped beats.

Yes

No

3. My palpitations feel like stopped beats.

Yes

No

4. I feel my heart racing with my heart palpitations.

Yes

No

5. I feel my heart pounding with my heart palpitations.

Yes

No

6. I feel my heart fluttering with my heart palpitations.

Yes

No

7. There is a regular pattern to my heart palpitations.

Yes

No

8. There is an irregular pattern to my heart palpitations.

Yes

No

9. I first started experiencing symptoms _____ (Month) _____ (Year).

10. I feel the palpitations when I _____.

11. The palpitations seem to stop when I _____.

12. I am having additional symptoms (for example, dizziness, shortness of breath, chest pain, fainting): _____.

13. I have a history of heart disease in my family.

Yes

No

If yes, please explain:

14. I have had emotional strains or recent life changes.

Yes

No

If yes, please explain:

15. I take the following medications (including over-the-counter medications):