



Study ID Number			_		
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PRE-DETERMINE STUDY - Follow-up Questionnaire

DATE OF BIRTH:] - 🔲	
PLEASE UPDATE US ON YOUR CURRENT HEALTH HISTORY SINCE YOU LAST PROVIDED INFORMATION, WHICH WAS ON THE FOLLOWING DATE: MO MO	/	YR
1.) HAVE YOU BEEN HOSPITALIZED DUE TO A CARDIAC ARREST (HEART SUDDENLY STOPS BEATING AIR RESUSCITATED)?	ND NEEDS T	O BE
O NO O NOT SURE O YES $ ightarrow$ IF YES, PLEASE PROVIDE MONTH/YEAR OF HOSPITALIZATION	I: MO	/
2.) HAVE YOU RECEIVED SURGERY TO HAVE AN IMPLANTABLE CARDIAC DEFIBRILLATOR (ICD) DEVICE	IMPLANTED)?
O NO O YES \Rightarrow IF YES, PLEASE PROVIDE MONTH/YEAR OF SURGERY: \bigcup_{MO} / \bigcup_{YR}		
3.) IF YOU HAVE AN ICD, HAVE YOU RECEIVED A SHOCK FROM YOUR ICD?		
O NO O NOT SURE O YES		
a.) HOW MANY SHOCKS HAVE YOU RECEIVED?		
b.) WHEN WAS YOUR LAST SHOCK? MO / YR		
4.) HAVE YOU BEEN DIAGNOSED WITH CONGESTIVE HEART FAILURE (FLUID IN LUNGS)?		
O NO O NOT SURE O YES $ ightarrow$ IF YES, PLEASE PROVIDE MONTH / YEAR OF DIAGNOSIS:		
5.) HAVE YOU BEEN HOSPITALIZED WITH A HEART ATTACK (NARROWING OR COMPLETE BLOCKAGE O ARTERY THAT RESULTS IN DEATH OF THE HEART MUSCLE)?	MO OF A CORONA	YR ARY
O NO O NOT SURE O YES \rightarrow <u>IF YES</u> , PLEASE PROVIDE MONTH / YEAR:	/	YR
6.) HAVE YOU BEEN DIAGNOSED WITH ATRIAL FIBRILLATION OR ATRIAL FLUTTER (ABNORMAL HEART	RHYTHM)?	
O NO O NOT SURE O YES \Rightarrow IF YES, PLEASE PROVIDE MONTH / YEAR OF DIAGNOSIS:	/	YR
7.) HAVE YOU HAD CORONARY BYPASS GRAFTING (OPEN HEART SURGERY TO REPLACE A NARROWEL ARTERY TO THE HEART)?	-	iĸ
O NO O NOT SURE O YES $ ightarrow$ IF YES, PLEASE PROVIDE MONTH / YEAR OF PROCEDURE:	/	
8.) HAVE YOU HAD A PERCUTANEOUS INTERVENTION (CORONARY STENT OR ANGIOPLASTY)?	МО	YR
O NO O NOT SURE O YES \Rightarrow <u>IF YES</u> , PLEASE PROVIDE MONTH / YEAR OF PROCEDURE:		VP.
OFFICE USE: O DE O UNF O BLNK O REFU O PH O PROXY	МО	YR



Study ID Number:

The information below is currently on file. If there are NO CHANGES, please leave as is. If there are changes, please provide the updated information in the right column.

STUDY PARTICIPANT:		UPDATE YOUR INFORMATION:				
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		City	State	Zip Cod		
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()		Cell Phone				
CONTACT #4.			E-mail Address			
CONTACT #1:		UPDATE CONTACT #1:				
			Contact #1 Name			
			Street Address			
			Street Address 2			
() -		City	State	Zip Code		
(Relationship		Home Phone		
()		Cell Phone		Work Phone		
CONTACT #2:		UPDATE CONTACT #2:				
		-	Contact #2 Name			
			Street Address			
			Street Address2			
		City	State	Zip Code		
· · · · · · · · · · · · · · · · · · ·		Relationship		Home Phone		
()		Cell Phone		Work Phone		
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Primary Care Physician Phone: () -	, MD	Primary Care Phys	sician			
(, MD	Phone				
Cardiologist Phone: () -	,	Cardiologist				
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Electrophysiologist	, -	Electrophysiologist	l .			

Phone