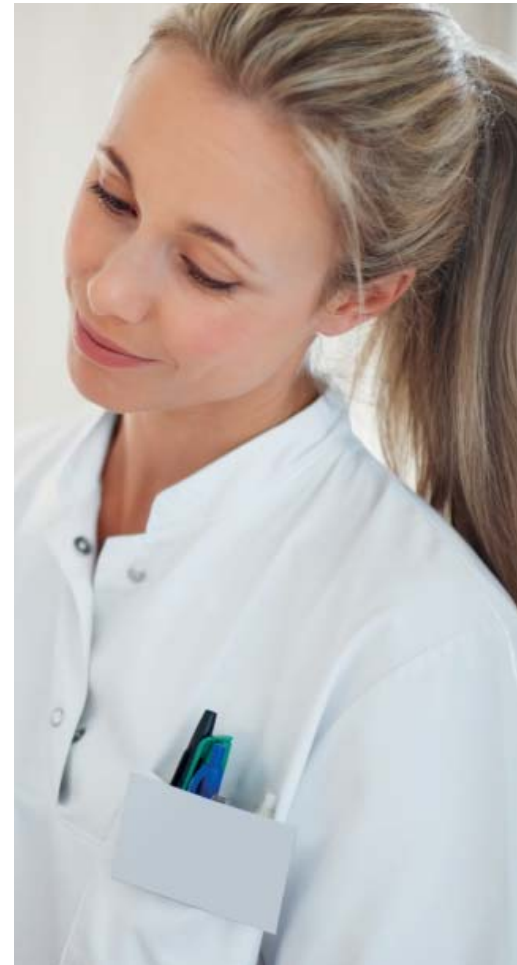


Atrial fibrillation checklist



Working together to provide information, support and access to established, new or innovative treatments for atrial fibrillation

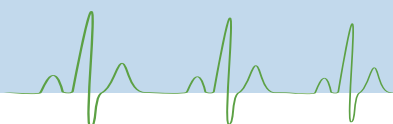
Atrial fibrillation checklist

This checklist is designed to provide your doctor or specialist with information they can use to choose the best treatment for you if you have been diagnosed with atrial fibrillation.

Atrial fibrillation and atrial flutter are common heart rhythm disturbances which may result in complications such as heart failure (sluggish beating of the heart) or sometimes stroke. Symptoms include palpitations, breathlessness, chest pain and tiredness.

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 provide that important information to your doctor. It would be useful to complete the form prior to visiting your doctor. Do not worry if there are any technical terms you do not understand – just put a question mark.



Your name

Date of birth: / /

Gender

Male

Female

Do you suffer from any of these symptoms?

	Yes	No	When (date)
Palpitations lasting more than 15 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"/>
At rest	<input type="checkbox"/>	<input type="checkbox"/>
With palpitations	<input type="checkbox"/>	<input type="checkbox"/>
When exercising	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
At rest	<input type="checkbox"/>	<input type="checkbox"/>
With palpitations	<input type="checkbox"/>	<input type="checkbox"/>
During exercise	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any of these medical conditions or procedures?

	Yes	No	When (date)
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 (mini-stroke)	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Electrical cardioversion	<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"/>
Vascular disease / problems with arteries	<input type="checkbox"/>	<input type="checkbox"/>

Have you been given a definite diagnosis of:

	Yes	No	Since when
Atrial fibrillation?	<input type="checkbox"/>	<input type="checkbox"/>
Atrial flutter?	<input type="checkbox"/>	<input type="checkbox"/>

Is your heart rhythm problem...

	Yes	No	Since when
Occuring as attacks?	<input type="checkbox"/>	<input type="checkbox"/>
Present at all times?	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently, or have you ever been treated with any of these medicines?

Since when

Amiodarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Apixaban (Eliquis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aspirin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beta blocker*	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rate limiting calcium channel blockers* (diltiazem, verapamil)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clopidogrel	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dabigatran etexilate (Pradaxa)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Digoxin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Dronedarone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Edoxaban (Lixiana)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Flecainide	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Propafenone	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rivaroxaban (Xarelto)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sotalol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Statins	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Verapamil	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Warfarin	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Vitamin supplements / alternative remedies	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Have you seen another doctor about your condition?

When (date)

GP / Family doctor	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Casualty doctor / A&E department	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"/>
Heart Rhythm doctor (electrophysiologist) / arrhythmia nurse specialist	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 24hr, 48hr, 7 day, 14 day 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

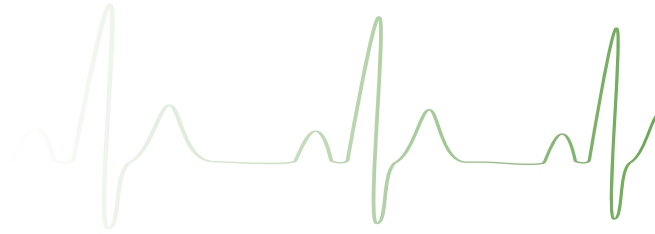
When (date)

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 ***Calcium channel blockers** = diltiazem (Adizem, Calcicard, Dilzem, Slozem, Tildiem) or verapamil (Cordilox, Securon, Univer, Vertab, Zolvera)

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

***TIA (mini-stroke)** = transient ischaemic attacks



Providing information,
support and access to
established, new or
innovative treatments
for atrial fibrillation



AF Association

+44 (0)1789 867 502

info@afa.org.uk

www.afa.org.uk

Registered Charity No. 1122442

©AF Association

Published March 2010
Reviewed September 2021

endorsed by
DH Department
of Health



FINGER ON YOUR PULSE

Finger on your Pulse: is our new library of educational video resources. Medical Experts share their knowledge and address specific concerns and patients share their experience living with the various conditions and treatments.

www.fingeronyourpulse.org

I found it so much easier to have
something in writing to present to the
doctor - the checklist is must for anyone
Amy in Lincolnshire

Please remember that this publication provides general information. You should always discuss and seek advice from your healthcare professional what is most appropriate for you.

Acknowledgments: AF Association would like to thank all those who helped in the development and review of this publication. Particular thanks are given to Dr Andreas Wolff, Dr Matthew Fay and Dr Charlotte D'Souza.

Founder and CEO:

Trudie Lobban MBE, FRCP (Edin)

If you would like further information or feedback please contact AF Association.