



# Atrial fibrillation checklist



Working to provide information, support and access to established,  
new or innovative treatments for Atrial Fibrillation (AF)

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

Registered Charity No. 1122442

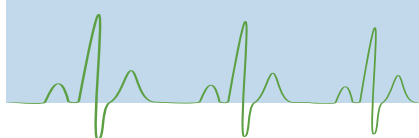
# Atrial fibrillation checklist

If you have been diagnosed with atrial fibrillation, this checklist is designed to provide your doctor or specialist with information they can use when choosing the best treatment for you.

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 on the accuracy of information provided by the patient.

This checklist is intended to help provide 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)
<b>Palpitations lasting more than 15 seconds</b>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Irregular	<input type="checkbox"/>	<input type="checkbox"/>	.....
Fast	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Breathlessness</b>	<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"/>	.....
<b>Chest pain</b>	<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"/>	.....
<b>Tiredness</b>	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Ankle swelling</b>	<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
Occurring 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 (Coumadin)	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)

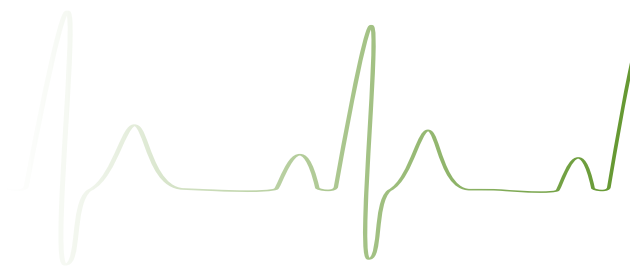
Resting ECG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Exercise ECG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Event ECG monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Implantable ECG monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
24hr, 48hr, 7 day, 14 day wearable 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)

Resting ECG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Exercise ECG	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*



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endorsed by  
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**"I found it so much easier to have  
something in writing to present to the  
doctor - the checklist is a must for anyone"**  
**Amy, Lincolnshire**

To view our patient resources, scan the  
QR code below:



Please remember that this publication  
provides general guidelines only. Individuals  
should always discuss their condition with  
a healthcare professional. If you would like  
further information or would like to provide  
feedback, please contact AF Association.

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**Founder and CEO:**  
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If you would like further information or would like to provide feedback please contact AF Association.