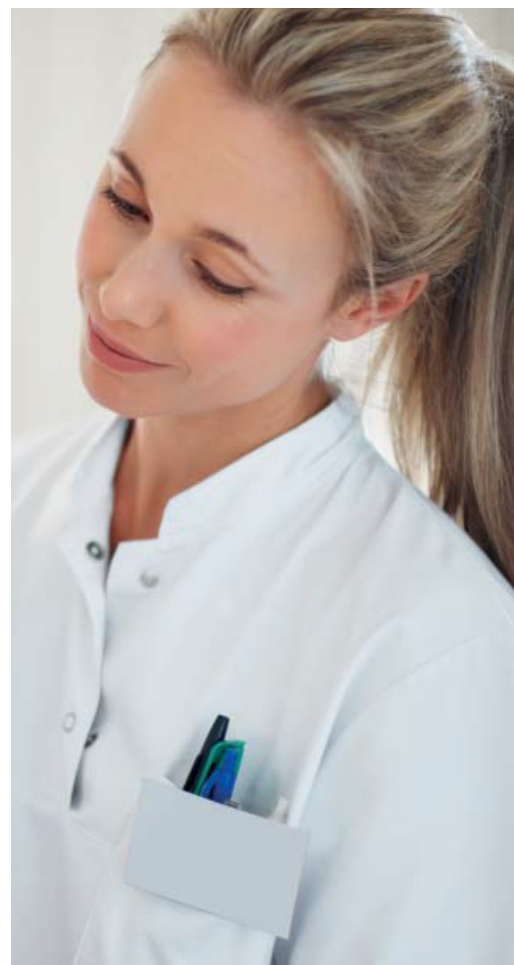


# Atrial Fibrillation Checklist



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

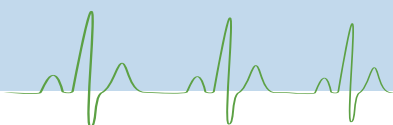
# Atrial fibrillation checklist

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 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 provide that important information to your doctor. It would be useful to complete the form to prior 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**   .....

Irregular   .....

Fast   .....

**Breathlessness**   .....

With palpitations   .....

When exercising   .....

**Chest pain**   .....

With palpitations   .....

During exercise   .....

**Tiredness**   .....

**Ankle swelling**   .....

**Have you had any of these medical conditions or procedures?** Yes No When (date)

Heart attack   .....

High blood pressure   .....

Heart failure   .....

Thyroid disturbances   .....

Diabetes   .....

Stroke or \*TIA (mini-stroke)   .....

Heart surgery   .....

Electrical shock treatment for your heart   .....

Ablation treatment   .....

Pacemaker implantation   .....

ICD implantation   .....

Vascular disease / problems with arteries   .....

**Have you been given a definite diagnosis of:** Yes No Since when

Atrial fibrillation?   .....

Atrial flutter?   .....

**Is your heart rhythm problem...** Yes No Since when

Occuring as attacks?   .....

Present at all times?   .....

**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"/>	.....
Channel blocker* (calcium, potassium or sodium)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	.....
Candesartan	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"/>	.....
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"/>	.....
Rhythm doctor / 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 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 = verapamil or diltiazem*

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

*\*Transient ischaemic attack (mini-stroke) = transient ischemic attacks*

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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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