

CLINICAL INFORMATION FORM

Patient's name: _____

 Gender: Male Female Date of Birth: _____

Diagnosis: _____

Age at Diagnosis: _____ Ethnic Background _____

 Race: Caucasian/White Black or African American American Indian/ Alaska Native
 Asian More than one race Other _____

 Date of diagnosis (date of the first abnormal ECG recorded, in presence or absence of symptoms):

 Family history: _____

Medical History

 Symptoms at diagnosis (ie: Sudden or aborted sudden death, syncope of unknown origin, vasovagal syncope, atrial fibrillation, etc.) _____

 Cardiac _____

 Non-cardiac. _____

EPS

	EPS Basal	EPS Drug Challenge
Not available		
Drug	None	
Inducible		
Not inducible		
N°Extras(1,2,3)		
HV Interval (msec)		

 • Other cardiac tests: _____

 • Treatment after diagnosis: ICD Beta Blockers Amiodarone Quinidine
 No treatment Other _____

 Death: Yes No Date of death: _____

Cause of death: _____

Please include include copies of ECGs performed and all other relevant information and test results that you feel are important.

Thank you very much for you cooperation.

I, Dr....., authorize the Masonic Medical Research Laboratory to use the data concerning my patient (s) and to list my name and institution in the appendix of cooperative centers. Patient's name will remain confidential.

 Signature

 Insitution

 Date