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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. _____

_____

Infectious Disease ☐Yes ☐No ☐ Unknown If Yes ☐HIV ☐Hepitasis C ☐Fungal Disease ☐Other _____

EPS

	EPS Basal	EPS Drug Challenge
Not available		
Drug		
Inducible		
Not inducible		
NºExtras(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