**Palpitation Service Cardiology**

**Patient Questionnaire for Palpitation Symptoms**  
Tick appropriate box/boxes

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Information | | | |
| First Names: |  | **Surname:** |  |
| Address: |  | | |
| DOB: |  | NHS No: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Which of the following best describes your symptoms?** | **How long do the symptoms last?** | | **How often are the symptoms?** | | |
|  | **Seconds** | **Minutes** | **Daily** | **Weekly** | **Monthly** |
| **Pounding / Thumping** |  |  |  |  |  |
| **Fluttering** |  |  |  |  |  |
| **Irregular heartbeat** |  |  |  |  |  |
| **Missed beats** |  |  |  |  |  |
| **Extra beats** |  |  |  |  |  |
| **Fast heartbeat** |  |  |  |  |  |
| **Slow heartbeat** |  |  |  |  |  |
| **Dizziness** |  |  |  |  |  |
| **Blackouts** |  |  |  |  |  |

**Please provide additional information if necessary:**