

Date Medical History Performed	___ / ___ / ___ (DD/MMM/YYYY)		
Rationale for seeking a non-pharmacologic alternative to OAC (Check all that apply)	<input type="checkbox"/> Drug regimen not compatible with OAC <input type="checkbox"/> Non-compliance to medication or monitoring schedule <input type="checkbox"/> History of bleeding or high bleeding risk <input type="checkbox"/> Renal failure <input type="checkbox"/> High fall risk <input type="checkbox"/> Other, specify: _____		
Documented type of non-valvular atrial fibrillation:	<input type="checkbox"/> Paroxysmal <input type="checkbox"/> Persistent <input type="checkbox"/> Permanent		
Does the subject have a medical condition that mandates long term oral anticoagulation?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No		
Diabetes mellitus (DM)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, please select one:	<input type="checkbox"/> Insulin dependent diabetes mellitus (IDDM) <input type="checkbox"/> Type I DM <input type="checkbox"/> Type II DM <input type="checkbox"/> Unknown <input type="checkbox"/> Non-insulin Dependent Diabetes Mellitus How is NIDDM controlled? <input type="checkbox"/> Diet <input type="checkbox"/> Oral Hypoglycemics <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown	
History of hypertension (Systolic BP > 140 mmHg, or Diastolic BP >90 mmHg)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, currently requires medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of hyperlipidemia (medical diagnosis) or total cholesterol >200?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, currently requires medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of peripheral vascular disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, prior intervention?	<input type="checkbox"/> Yes (check all that apply) <input type="checkbox"/> Percutaneous <input type="checkbox"/> Surgical <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Unknown

History of carotid artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, location	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	
		If yes, prior intervention?	<input type="checkbox"/> Yes, specify: <input type="checkbox"/> Endarterectomy <input type="checkbox"/> Stent <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Prior cerebral vascular accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of most recent CVA:	___ / ___ / ___ (DD/MMM/YYYY)	
		If yes, is imaging available?	<input type="checkbox"/> Yes Date of most recent Brain Scan MRI or CT Imaging: ___ / ___ / ___ (DD/MMM/YYYY) <input type="checkbox"/> No	
		If yes, specify type (Check all that apply)	<input type="checkbox"/> Ischemic <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Unknown	
Prior traumatic intracranial hemorrhage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of most recent intracranial hemorrhage:	___ / ___ / ___ (DD/MMM/YYYY)	
		If yes, is imaging available?	<input type="checkbox"/> Yes Date of most recent imaging: ___ / ___ / ___ (DD/MMM/YYYY) <input type="checkbox"/> No	
		If yes, specify type (Check all that apply)	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Traumatic	
Prior transient ischemic attack?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of most recent TIA:	___ / ___ / ___ (DD/MMM/YYYY)	
History of coronary artery disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, current anginal status	<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Stable Angina <input type="checkbox"/> Unstable Angina	
		If yes, prior coronary artery intervention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify type: <input type="checkbox"/> Percutaneous <input type="checkbox"/> Surgical

History of congestive heart failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, NYHA Functional Class	<input type="checkbox"/> Class I <input type="checkbox"/> Class II <input type="checkbox"/> Class III <input type="checkbox"/> Class IV (<i>Review for I&E!</i>)
What is the most recently documented LVEF (%)? (xx)	_____ %	___ / ___ / _____ (DD/MMM/YYYY)	
History of intracardiac mass, thrombus or vegetation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify location	<input type="checkbox"/> Left Ventricle <input type="checkbox"/> Left Atrium <input type="checkbox"/> Left Atrial Appendage <input type="checkbox"/> Other, specify:
History of severe valvular heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify type (<i>Check all that apply</i>)	<input type="checkbox"/> Aortic valve stenosis <input type="checkbox"/> Aortic valve regurgitation <input type="checkbox"/> Mitral valve stenosis <input type="checkbox"/> Mitral valve regurgitation <input type="checkbox"/> Tricuspid valve stenosis <input type="checkbox"/> Tricuspid valve regurgitation <input type="checkbox"/> Unknown
Does the subject have history of prior cardiac transplant, history of mitral valve replacement or transcatheter mitral valve intervention, or any mechanical valve implant?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No		
History of procedure to convert atrial fibrillation to atrial flutter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, specify type	<input type="checkbox"/> Cardioversion <input type="checkbox"/> Ablation <input type="checkbox"/> Both Cardioversion and Ablation
History of acute or chronic pericarditis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Has the subject had a cardiac or non-cardiac intervention or surgical procedure within 30 days of the index procedure?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No		
Does the subject have a planned surgical procedure within 60 days AFTER the date of the planned Index Procedure Date?	<input type="checkbox"/> Yes (<i>Review for I&E!</i>) <input type="checkbox"/> No		

History of myocardial infarction?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, most recent date:	____/____/____ (DD/MMM/YYYY)
History of cardiomyopathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of patent foramen ovale (PFO)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of atrial septal defect (ASD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of gastrointestinal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of other form of recurrent systemic bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of anemia requiring transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of renal disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
History of dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Does subject have history of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Patient declined to answer		
Has subject received COVID-19 vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Patient declined to answer		

Site Personnel Signature

____/____/____
Date (DD/MMM/YYYY)