VENTRICULAR ARRHYTHMIA QUESTIONNAIRE

Local Center Name _____

PRINT Patient Name _____
Last First M.I.

Date of Event MO __ __ Day __ __ Yr __ __

Randomization Number
__ __ __ / __ __ __ __

A. Information on the patient PRIOR to randomization:

1. Did the patient have a history of ventricular tachycardia or fibrillation prior to randomization? (1=Yes, 0=No) Q1

a) If Yes, what type of ventricular arrhythmias did the patient have? (use codes below) Q1A

1=ventricular tachycardia
2=ventricular fibrillation
3=both

B. Information on the patient **AFTER** randomization and at the time of suspected digoxin toxicity:

3. Was the patient hospitalized for this episode of suspected digoxin toxicity? (1=Yes, 0=No) Q3

a) If yes, what was the primary reason for the hospitalization?

_____

4. Did the patient have any significant presyncopal symptoms or syncope in conjunction with the ventricular arrhythmia? (1=Yes, 0=No) Q4

5. What type of ventricular arrhythmia did the patient have? (use codes below) Q5

1=ventricular tachycardia
2=ventricular fibrillation
3=both

C. If the patient had ventricular tachycardia, complete the following:

6. Did the patient have unsustained ventricular tachycardia? (1-Yes, 0=No) Q6

VA Form 10-20914h(NR)
JAN 1991

7. Did the patient have sustained ventricular tachycardia? (1=Yes, 0=No) . Q7

a) If yes, how long did it last? ..... Q7A_MIN : Q7A_SEC
Min Sec

b) If yes, what was the ventricular rate? Q7B

8. The patient was treated for this episode of ventricular tachycardia as follows: (1=Yes, 0=No)

a) Treatment Q8A

b) Intravenous lidocaine Q8B

c) Defibrillator/cardioversion Q8C

d) Pacing Q8D

e) Other (specify _____Q8E_SPEC_____

D. If the patient had ventricular fibrillation, complete the following: (1=Yes, 0=No)

9. Was it preceeded by:

a) Torsades Q9A

b) Other ventricular tachycardia? Q9B

10. Was the patient treated with a defibrillator? Q10

E. Complete the following:

11. Last name and first initial of individual completing this form (IN CAPITALS)_____
Last Name First Initial

_____
Signature

Please send a copy of the diagnostic ECG or rhythm strip. If hospitalized, please send a copy of hospital discharge summary or a narrative explaining the situation for the diagnosis.

PLEASE RETURN FORM TO DATA COORDINATING CENTER AT PERRY POINT

VA Form 10-20914h(NR)
JAN 1991