conformal THE SHAPE OF STROKE PREVENTION	**CONFORM Medical History** ☐ Source ☐ Data Transfer Tool
	Site Number: _____ Subject ID: _____

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

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

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

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

_____
Site Personnel Signature

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