PATIENT INFORMATION AND INSTRUCTIONS

Before leaving, you should read this booklet entirely to see if you have any questions regarding this procedure.

Your physician has recommended a Holter Electrocardiogram for the purpose of determining how your heart functions during your normal everyday activities. Your physician will require you to log your activities in this diary while you are wearing the Holter Recorder. Use this diary to record the following:

Time of day..... Record the time from the clock on the recorder.
Do Not Use Your Watch or Other Timepiece.

Activity..... For anything you do during this procedure; sitting, eating, taking medication, walking, strenuous exercise, smoking, bowel movements, urinating, sexual intercourse, etc.

Symptoms..... During your activity make sure to write down any abnormalities that may occur, such as pains in your chest, neck, arm or face. Include any dizziness, heart pounding, nausea, or shortness of breath. Only make a notation if you feel something abnormal, otherwise, leave the “symptom” column blank.

IMPORTANT NOTES TO PATIENT

To insure an accurate evaluation of this recording, it is necessary that you keep a continual diary for 24 hours. This diary must include your activities, the time of these activities as shown on the recorder clock, and how you feel at the time. If you are unsure of the significance of a feeling, write it down.

1. Do not get the recorder wet. Do not bathe, shower, or swim during this monitoring period.

2. Do not open the recorder or tamper with it, or the lead wires. If you should notice any disconnection of the cable or wires into the recorder, please call the technician.

Following these instructions will help your physician analyze the results of your recording using specially designed equipment

- SAMPLE DIARY -

TIME	ACTIVITY	SYMPTOMS
9:20	Mowing Lawn	Chest pain
10:30	To bathroom to urinate	
12:00	Driving	Heart beats faster
9:00	To bed	

TIME	ACTIVITY	SYMPTOMS

HOLTER ECG

Patient Diary

☐ 24 HOUR
☐ 48 HOUR
☐ _____

PATIENT: _____

PHYSICIAN: _____

HOSPITAL OR
OFFICE LOCATION: _____

SEX	AGE	WEIGHT	HEIGHT

DATE OF RECORDING: _____

RECORDER S/N NO: _____

TIME OF TEST:

START	STOP
_____ AM	_____ AM
_____ PM	_____ PM

MEDICATIONS: _____

_____

_____

_____

TIME	ACTIVITY	SYMPTOMS

TIME	ACTIVITY	SYMPTOMS