Canberra Heart Clinic
Lidia Perin Medical Centre
Suite 1, 12 Napier Close
Deakin, ACT, 2600
Ph: 02 6162 1886
Fax: 02 6162 1887

www.canberra-heart-clinic.com.au

info@canberraheart.com.au

Please carefully fill in both sides of this form prior to your consultation

Surname:					
First Name(s):				**Date of Birth:**	
Address:					
Suburb:				**Postcode:**	
Occupation:					
Home Ph:		**Work Ph:**		**Mobile Ph:**	
Private Health Insurance Fund:					
Fund Membership Number:					
Medicare No:		**Number beside Name**		**Expiry Date:**	/ /
Pension/Health Care Card No:				**Email Address:**	
DVA Gold Card No:				**TAC Claim No:**	
Referring Doctor:					
General Practitioner:					
Next of Kin:					
Emergency Contact Number:					

I _____ give my permission for
(PLEASE PRINT YOUR NAME)

any correspondence / results which will assist in my treatment to be sent or faxed (Fax No. 02 6162 1887) to my cardiologist at the Canberra Heart Clinic.

I have also read the privacy and access policies of this practice and agree to its contents.

Signed: _____

Date: ____/____/____

YOUR MEDICAL HISTORY

PAST CARDIAC HISTORY

CARDIAC RISK FACTORS	
FAMILY HISTORY OF HEART ATTACKS	
SMOKER CURRENT	
EX	
NEVER	
HIGH BLOOD PRESSURE	
DIABETES	
HIGH CHOLESTEROL	

OTHER PAST HISTORY:

CONDITION	WHEN DIAGNOSED

MEDICATIONS:

DRUG NAME	DRUG DOSE	FREQUENCY

MEDICATION ALLERGIES:
