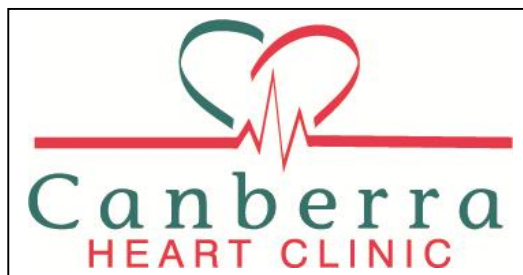


Canberra Heart Clinic
 Lidia Perin Medical Centre
 Suite 1, 12 Napier Close
 Deakin, ACT, 2600
 Ph: 02 6162 1886
 Fax: 02 6162 1887

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 |
|----------------------|
| |
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| |
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| |

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

OTHER PAST HISTORY:

| CONDITION | WHEN DIAGNOSED |
|-----------|----------------|
| | |
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| | |

MEDICATIONS:

| DRUG NAME | DRUG DOSE | FREQUENCY |
|-----------|-----------|-----------|
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MEDICATION ALLERGIES:

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