

Please carefully fill in BOTH SIDES of this form prior to your consultation with your cardiologist

Surname:		First Name(s):	
Address:			
Date of Birth:			
Occupation:			
Mobile phone number:			
Home phone number:			
Work phone number:			
Email address:			
Private Health Insurance Fund:			
Private Health Insurance Fund Membership Number:			
Medicare card number (10 Digits):			
Number in front of name on Medicare card:		Expiry Date:	
Concession Card Number:		Expiry date:	
DVA Gold Card No:		PMKeys:	
Referring Doctor:			
Usual General Practitioner:			
Name and phone number (next of kin) in case of emergency:			

I, **Parminder Kaur**, give my permission for any correspondence / results which will assist in my treatment to be sent or faxed (Fax No. 02 6162 1887) to us at the Canberra Heart Clinic.

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

Signed: _____

Date: ____/____/____

Please complete your medical history over the page

MEDICATION ALLERGIES

MEDICATION ALLERGY

REACTION

CARDIAC RISK FACTORS (PLEASE CIRCLE)

PAST CARDIAC HISTORY

SMOKER: Current / Ex / Never

Number per day:

Year Quit:

HIGH BLOOD PRESSURE: Yes / No

DIABETES: Yes / No Type:

HIGH CHOLESTEROL: Yes / No

FAMILY HISTORY OF HEART ATTACKS: Yes / No Details:

OTHER MEDICAL HISTORY

CONDITION/PROCEDURE

YEAR

MEDICATION LIST

MEDICATION NAME

TABLET STRENGTH

NO. OF TABLETS

TIMES TAKEN