Canberra heart clinic

Lidia Perin Medical Centre
Suite 1, 12 Napier Close
DEAKIN ACT 2600
Ph (02) 6162 1886
Fax (02) 6162 1887

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 , 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