Name:

Age: DOB:

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:	

PLEASE FAX OR EMAIL AN UPDATED MEDICATION LIST THROUGH TOGETHER WITH THIS WORKSHEET ONCE COMPLETED. PLEASE RING THE ROOMS ON 6162 1886 ONCE THIS HAS BEEN DONE. IT IS IMPORTANT TO ALLOW 20 MINUTES SO THE DATA SUPPLIED IS ENTERED ONTO OUR SYSTEM PRIOR TO STARTING THE TELECONSULATATION WITH YOUR SPECIALIST.

Method of patient contact (please circle one option) - **Home phone** ◯ **Mobile phone** ◯

Skype id: ◯

Past History:

Allergies: Yes ◯ No ◯

PLEASE PROVIDE MEASUREMENTS BELOW-

Height : **(with no shoes)**	**cm**
Weight : **(with no shoes or heavy clothing):**	**kg**
Heart rate:	**bpm**
Waist measurement :	**cm**

(place tape around patient's waist, measure roughly in line with belly button)

**** Kindly fax or email this document to 02 6162 1887 or reception@canberraheart.com.au along with a recent ECG trace and updated medication list.***

PLEASE PROVIDE 3 BLOOD PRESSURE READINGS AS INDICATED BELOW -

1st BP lying:	**mm/Hg**
2nd BP on immediate standing:	**mm/Hg**
3rd BP after 1 min prolonged standing :	**mm/Hg**

Please take an ECG reading if possible, otherwise please provide a recent ECG trace.

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