THE CARDIAC CLINIC

The Cardiac Clinic
Suite 1, Level 2, Dubbo Private Hopsital
Moran Dve, Dubbo NSW 2830

Ph: 02 6841 8820
Fax: 02 6841 8828

NEW PATIENT MEDICAL HISTORY FORM

DATE: _____ _____

NAME: _____

D.O.B.:_____ AGE: _____ GENERAL PRACTITIONER: _____

REASON FOR VISIT: _____

_____

MEDICATION LIST ATTACH PRINTOUT

MEDICATION	DOSE	TIMES PER DAY

MEDICATION	DOSE	TIMES PER DAY

ALLERGIES:

Shellfish? ☐ No ☐ Yes, Reaction: _____

Iodine/Contrast Dye/X-Ray Dye? ☐ No ☐ Yes, Reaction: _____

MEDICATION ALLERGY	REACTION/SIDE EFFECT

PAST MEDICAL HISTORY

MEDICAL CONDITION	DATE OF ONSET	TREATING DOCTOR	DETAILS
Aneurysm			
Anxiety			
Arrythmia			
Atrial Fibrillation			
Bleeding Problems			
Blood Clots			
Cancer			
Cardiac Arrest			
Circulation problems			
Congenital Heart Disease			
Coronary Artery Disease			
Depression			
Diabetes			
Digestive Problems			
Fainting/Syncope			
Hearing Impaired			Hearing aid? YES NO Interpreter requested? YES NO
Heart Attack			
Heart Failure			
Heart Murmur			
Heart Valve Problems			
Heartburn			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Liver Disease			
Lung Disease			
Palpitations			
Rheumatic Fever			
Seizures			
Sleep Disorders			
Stroke			
Thyroid Problems			
Varicose veins			
Vision Impairment			Glasses/Contacts? YES NO

OTHER PAST MEDICAL HISTORY: _____

_____

_____ _____

PAST SURGICAL HISTORY:

OPERATION	DATE	DETAILS

FAMILY HISTORY:

√	MEDICAL HISTORY	FAMILY MEMBERS	AGES OF ONSET
	Aneurysm		
	Arrythmia		
	Bleeding Problems		
	Blood Clots		
	Circulation problems		
	Congenital Heart Disease		
	Coronary Artery Disease		
	Diabetes		
	Fainting/Syncope		
	Heart Attack		
	Heart Failure		
	Heart Murmur		
	Heart Surgery		
	Heart Valve Problems		
	High Blood Pressure		
	High Cholesterol		
	Kidney Disease		
	Rheumatic Heart Disease		
	Stroke		
	Sudden Death		
	Thyroid Problems		
	Other:		

SOCIAL HISTORY:

Primary Language:_____ Translator Needed? YES NO Religion:_____

Do you have any cultural or religious customs that we should be aware of? YES NO

If YES, please explain:_____

TOBACCO

	Never	Current	Former	Age of Onset	PPD	# years	Year Quit
Cigarettes							
Pipe							
Cigar							

ALCOHOL/CONTROLLED SUBSTANCES

Type	Amount	Frequency	Quit

PREVIOUS CARDIAC PROCEDURES:

TEST	WHERE?	WHEN?	DETAILS
Ablation of Arrythmia			
Angioplasty/Stent			
Cardioversion			
Coronary Bypass Surgery			
Defibrillator Implant			
Echocardiogram			
Electrophysiology Study			
Event Recorder			
Heart Catheterization			
Heart CT Scan			
Heart Valve Surgery			
Holter			
Permanent Pacemaker			
Stress Test			
TEE			
Other:			

DO YOU HAVE ANY OF THE FOLLOWING?

	Abdominal pain, nausea, vomiting		Dark or bloody stools
	Anemia, easy bruising		Decreased appetite
	Arthritis, muscle weakness		Difficulty hearing, nose bleeds, sinus problems
	Asthma, bronchitis, emphysema		Fever, chills, shakes
	Can't walk on a treadmill		Recent weight loss greater than 5 pounds
	Change in exercise tolerance		Seizures
	Change in vision, cataracts, glaucoma		Shortness of breath
	Chest pain, chest tightness		Skin rashes, skin cancer
	Constipation, diarrhea		Unexplained weight gain

If yes, explain: _____

_____

RECENT HOSPITALIZATION: ☐ No ☐ Yes, Location/Dates: _____

Details: _____

RECENT CARDIAC INVESTIGATIONS : ☐ No ☐ Yes , Location: _____ Date: _____

WHERE DO YOU GO FOR BLOOD WORK? ☐ Douglas Hanly Moir ☐ Dubbo Base Hospital

☐ Other: _____ P