PORT MACQUARIE CARDIOLOGY

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Port Macquarie NSW 2444
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ABN: 82 157 836 615

Personal Details

Surname	**Given Names**	**Date of Birth**
Address	Telephone number/mobile	
Next of Kin name:	Relationship to self	

Medical information: Please list all medications you take including dose and how often you take them.

Allergies – please list	

Recent Cardiac surgery	**When**	**Where**

Please complete the following:

Do you smoke cigarettes	**Yes No**	**Do you drink alcohol**	**Yes No**
If ceased how long ago		**If yes, no of standard drinks per day**	
Do you have diabetes	**Yes No**	**Do you have high blood pressure**	**Yes No**
Do you have high cholesterol	**Yes No**	**Have you had any recent pathology or chest x-rays**	**Yes No**
Have you seen a Cardiologist previously	**Yes No**	**If YES please bring any previous correspondence**	

Family History – Please list any health problems, particularly cardiac.

Father	
Mother	
Siblings	
Any other health conditions in the family	