

Patient Medical History Form



PATIENT DETAILS												
Title	<input type="checkbox"/>	Mr	<input type="checkbox"/>	Mrs	<input type="checkbox"/>	Ms	<input type="checkbox"/>	Miss	<input type="checkbox"/>	Dr	<input type="checkbox"/>	Other
Last Name					First Name							
Date of Birth					Preferred Name							

GENERAL MEDICAL HISTORY				
<input type="checkbox"/> Lung	<input type="checkbox"/> Neurological	<input type="checkbox"/> Liver	<input type="checkbox"/> Kidney	<input type="checkbox"/> Cancer
<input type="checkbox"/> Sleep Apnoea	<input type="checkbox"/> Clotting/bleeding	<input type="checkbox"/> Mental Health		<input type="checkbox"/> Other:

GENERAL					
Height	cm		Weight	kg	
	ft			lbs	

CARDIAC HISTORY			
<input type="checkbox"/> Do you have known coronary artery disease?			
<input type="checkbox"/> Do you have / are you treated for blood pressure?			
<input type="checkbox"/> Do you have / are you treated for high cholesterol?			
<input type="checkbox"/> Do you have / are you treated for Diabetes?			
<input type="checkbox"/> Do you currently smoke?	Cigarettes/week?		
<input type="checkbox"/> Are you an ex-smoker?	When did you stop?		
<input type="checkbox"/> Has anyone in your family had heart disease?	Relationship	Condition	Age at diagnosis

CARDIAC SYMPTOMS		
<input type="checkbox"/> Do you experience:	<input type="checkbox"/> chest pain	
	<input type="checkbox"/> chest discomfort	
	<input type="checkbox"/> chest heaviness	
<input type="checkbox"/> Do you experience these symptoms:	<input type="checkbox"/> at rest	
	<input type="checkbox"/> during the night	
	<input type="checkbox"/> getting worse	
<input type="checkbox"/> Do you experience shortness of breath:	<input type="checkbox"/> on exertion	
	<input type="checkbox"/> at rest	
	<input type="checkbox"/> during the night	
	<input type="checkbox"/> on lying down	
	<input type="checkbox"/> getting worse	
<input type="checkbox"/> Do you experience ankle swelling:	<input type="checkbox"/> all day	
	<input type="checkbox"/> at night	
<input type="checkbox"/> Do you experience palpitations:	<input type="checkbox"/> missed beats	
	<input type="checkbox"/> extra beats	
	<input type="checkbox"/> a racing heart	
	<input type="checkbox"/> collapse	
	<input type="checkbox"/> black outs	

Patient Medical History Form

CARDIAC INVESTIGATIONS				
<input type="checkbox"/> Blood tests	When?		Where?	
<input type="checkbox"/> CXR	When?		Where?	
<input type="checkbox"/> ECG	When?		Where?	
<input type="checkbox"/> Echocardiogram (thoracic)	When?		Where?	
<input type="checkbox"/> Echocardiogram (oesophageal)	When?		Where?	
<input type="checkbox"/> Stress ECG test	When?		Where?	
<input type="checkbox"/> Stress echo test	When?		Where?	
<input type="checkbox"/> Angiogram	When?		Where?	
	Cardiologist?			
<input type="checkbox"/> Angioplasty / stents	When?		Where?	
	Cardiologist?			
<input type="checkbox"/> CTCA (CT Coronary Angiogram)	When?		Where?	
<input type="checkbox"/> CT Calcium score	When?		Where?	
<input type="checkbox"/> Heart Valve Surgery	When?		Where?	
	Surgeon?			
<input type="checkbox"/> Coronary artery bypass surgery (CABG)	When?		Where?	
	Surgeon?			
<input type="checkbox"/> Pacemaker	When?		Where?	
	Cardiologist?			
	Brand?			

Once completed please email this form to patientdetails@healthyheartsmelbourne.com.au

Please visit our [Website](#) where you will find our handy [Healthy Hearts Melbourne Patient Checklist](#).