Patient Information Sheet

Mr/Mrs/Ms/Miss/Other:..... ....
Title (Circle One) First Name Surname

Address:
.....Home Phone: .....

Suburb: .....Work Phone: .....

State: ..... Postcode: ..... Mobile: .....

Date of Birth: .....

Please list all medication you take including dose and how often you take them. **(This is of critical importance)**

Allergies – please list	

Recent Cardiac Surgery	When	Where

Please complete the following:

Do you smoke cigarettes?	Yes No If yes, how many per day	Do you drink alcohol?	Yes No
If ceased, how long ago?		If yes, no. of standard drinks	
Have you ever had diabetes?	Yes No	Have you ever had high blood pressure?	Yes No
Have you ever had high cholesterol?	Yes No	Have you had any recent pathology or chest X-ray?	Yes No
Have you seen a cardiologist previously?	Yes No	If yes, please bring any previous correspondence in your possession.	

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

Father:	
Mother:	
Siblings:	
Any other common conditions in the family:	

Consent for Disclosure of Information:

I hereby give permission for the Dr Kevin Alford to:

1. Obtain medical information from any other practitioners, hospitals, and health care providers that pertains to my medical condition.
2. Communicate with the referring medical practitioner concerning my medical condition;
3. Communicate with other health professionals directly involved with my medical condition.

Name: (BLOCK LETTERS) .....

Signature: .....

Date: ..... Date of Birth: .....