CARDIOLOGY INSTITUTE

New patient form

Mr/Mrs/Ms/Miss _____ NHI _____
(first) (middle) (surname)

Address _____

DOB _____ Next of Kin _____

Phone: Home _____ Relationship _____

Phone: Mobile _____ Contact details_____

Occupation _____ Medical insurance? _____

GP _____ Policy Number _____

We usually email reports to you. Is this ok? Yes/No
Your Email _____

Please list your medications (as far as you can remember)

	mg	morning	noon	dinner	night
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Do you have any allergies? _____

Type of reaction: Rash? Swelling? Breathing? _____

Please list your other medical problems and operations

Medical problems	Dates	Operations	Dates

Have you experienced? (if so, please describe...)

Chest pain	
Shortness of breath	
Palpitations	
Dizziness / loss of consciousness	
Heartburn	

High blood pressure	Yes ☐ No ☐	How long has it been treated?
High cholesterol	Yes ☐ No ☐	How long has it been treated?
Smoking	Yes ☐ Ex ☐ Never ☐	How many cigarettes per day? When did you give up? How many years have (did) you smoke(d) for?
Diabetes	Yes ☐ No ☐	For how many years?
Stroke or TIA (mini-stroke)	Yes ☐ No ☐	When?
Parents, brothers, sisters have heart problems or aneurysm?	Yes ☐ No ☐	Who? At what age was it diagnosed?
Aneurysm of head, chest, abdomen	Yes ☐ No ☐	When?
Do you have to stop walking because of sore leg muscles?	Yes ☐ No ☐	Which legs? How far could you walk before stopping?
Varicose veins	Yes ☐ No ☐	Which legs? Above or below the knee?
Alcohol	Yes ☐ No ☐	How much? How often?
Regular exercise	Yes ☐ No ☐	What sort? How many days a week?