Bushidi's HEART CLINIC

The Town Centre
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PRE-CONSULTATION FORM

Please return this form AS SOON AS POSSIBLE by mail, fax or drop off.

Demographic:

Name: _____PHIN: _____ MHSC REG# _____

Home Phone Number: _____ Cell Phone Number: _____

Name of Family Physician: _____

Profession: _____ Pharmacy: _____

Diagnostic Imaging: _____ Preferred Lab Choice: _____

Next of Kin Name: _____ Next of Kin Phone: _____

E-Mail: _____

Preferred Method of Contact (**Please circle**): E-Mail Phone Mail

Main Symptoms:

- _____
- _____
- _____

Allergies: _____

Current Medications (Prescription and non- prescription):

Medication Name	Dose	Date Started

Cardiovascular Risk Factors (Please check off if you have any of these)

1) Diabetes Type 1 or 2 _____ 2) Hypertension _____ 3) High Cholesterol _____

4) Smoking _____ 5) Family History of Heart Attack _____

Past Medical and Surgical History

Surgery/Medical Condition	Date	Location (Where was it done)

Family History: *(First degree relatives – Parents or Siblings)*

Heart Failure _____ Heart Surgery _____ Heart Attack _____

Stent in Heart _____ Arrythmia _____ Sudden Death _____

Other Comments:

_____

_____

_____

Previous Cardiovascular Surgery or Procedures:

	Date	Location of Test
Coronary Stent		
Coronary Artery Bypass		
Cardiac Value Surgery		
Pacemaker		
Defibrillator		
Cardiac Ablation		

Previous Investigations:

	Date	Location of Test
ECG/EKG		
Holter Monitor		
24 HR Blood Pressure Monitor		
Echocardiography		
MUGA Scan		
MIBI		
Stress EKG		
Coronary Angiogram		

Lifestyle/Social History:

	Yes	No	How much do you use/do and for how many years
Alcohol			
Illicit Substance			
Marijuana, Cannabis, CBD Oils			
Exercise			
Smoking			
Feeling Stress			
Snoring			

Other Comments: