

PRE-CONSULTATION FORM

144-6th Street Brandon, MB R7A 3N2 TEL 204.717.7800 FAX 204.717.7801 bushidiheart.com contact@bushidiheart.com

Please return this form as soon as possible by mail, fax, or drop-off BEFORE your scheduled appointment.

		MUCC DEC#	
Home Phone Number:		PHIN: MHSC REG# Cell Phone Number:	
	Gen i none number.		
Profession:		:	
Diagnostic Imaging:		Preferred Lab Choice:	
Next of Kin Name:		Next of Kin Phone:	
	for Appointments/Notices (Please	circle): E-Mail or Mail	
_			
Allergies:			
Allergies:Current Medications (Preso	ription and non- prescription):		
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Family History: (First deg	gree relat	t <mark>ives - Parents</mark> o	or Siblings <u>Only</u>)
Heart Failure	Hear	t Surgery	Heart Attack
Stent in Heart	Arryt	thmia	Sudden Death
Other Comments:			
Past Medical and Surgica	ıl History	•	
Surgery/Medical Condi	tion	Date	Location (Where was it done)
Previous Cardiovascular	Surgery	or Procedures:	
	Jungery	Date	
Coronary Stent		Date	Location of Test
Coronary Artery Bypass			
Cardiac Value Surgery			
Pacemaker			
Defibrillator			
Cardiac Ablation			
Cartilat Abiation			
Duovious Investigations			
Previous Investigations:			
DOG (DV)		Date	Location of Test
ECG/EKG			
Holter Monitor			
24 HR Blood Pressure Mo	nitor		
Echocardiography			
MUGA Scan			
MIBI			
Stress EKG			
Coronary Angiogram			
Lifestyle/Social History:			
	Yes N	lo How much o	do you use/do and for how many years
Alcohol			
Illicit Substance			
Marijuana, Cannabis,			
CBD Oils			
Exercise			
Smoking			
Feeling Stress			
Snoring			