The HeartScreen.

Pre-Heart Sonography Patient Information and Consent Form

Patient Name: _____**Surname:** _____ **middle Names:**_____

Date of Birth: _____ **Residential Address:** _____

Contact Numbers: _____**Mobile:** _____ **Home:** _____

Email Adress: _____

Medicare Number: _____ **Reference:** _____**Expiry:** _____

DVA/Veteran Affairs: _____ **Gold** ☐ **White** ☐ **Number:** _____**Expiry:**

Do you have any concession cards:

Concession ☐ **Pension** ☐ **Healthcare** ☐

Card Number _____ **Expiry:** _____

Gender: ☐ Male ☐ Female ☐ Other

Date of Appointment: _____

Next of Kin / Emergency Contact Number: _____

Relationship to the patient: _____

Referring Physician (if any): _____

Section 1: General Medical History

1. **Do you have a history of any heart-related conditions?**
☐ No ☐ Yes (please specify): _____

2. **Do you have a history of any of the following conditions?** *(Check all that apply)*
☐ High blood pressure (Hypertension)
☐ Diabetes (Type 1 / Type 2)
☐ Blood clotting disorders
☐ Kidney disease
☐ Other: _____
☐ High cholesterol
☐ Stroke or mini-stroke (TIA)
☐ Autoimmune diseases (e.g., Lupus, Rheumatoid Arthritis)
☐ Thyroid disorders

3. **Do you have a family history of heart disease?**
☐ No ☐ Yes (who?): _____

4. **Have you ever had a heart attack or been diagnosed with myocarditis or pericarditis?**
☐ No ☐ Yes

5. **Have you ever had a previous echocardiogram or stress test?**
☐ No ☐ Yes (when?): _____

Section 2: COVID-19 & Vaccination History

Have you had COVID-19?
☐ No ☐ Yes (Date of infection): _____

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7. **If yes, did you experience any of the following symptoms post-COVID?** *(Check all that apply)*

☐ Chest pain or tightness
☐ Irregular heartbeats (palpitations)
☐ Dizziness or fainting
☐ Leg swelling
☐ Shortness of breath
☐ Fatigue
☐ Brain fog or memory issues
☐ Persistent cough ☐ Other: _____

8. **Have you received the COVID-19 vaccine?**

☐ No ☐ Yes (Which vaccine?): ☐ Pfizer ☐ Moderna ☐ AstraZeneca ☐ Novavax ☐ Johnson & Johnson

9. **How many doses have you received?**
☐ 1 ☐ 2 ☐ 3 ☐ 4+

10. **Did you experience any of the following post-vaccination symptoms?** *(Check all that apply and specify duration if applicable)*

☐ Chest pain or pressure (Duration: _____)
☐ Heart palpitations (Duration: _____)
☐ Swelling in legs or arms (Duration: _____)
☐ Numbness or tingling in extremities (Duration: _____)
☐ Other: _____
☐ Shortness of breath (Duration: _____)
☐ Fatigue (Duration: _____)
☐ Unusual bruising or bleeding (Duration: _____)
☐ Persistent headaches (Duration: _____)

Section 3: Lifestyle & Risk Factors

11. **Do you smoke?** ☐ No ☐ Yes (How many per day?): _____

12. **Do you drink alcohol?** ☐ No ☐ Yes (How many drinks per week?): _____

13. **Do you exercise regularly?** ☐ No ☐ Yes (Type and frequency): _____

14. **How would you describe your stress levels?** ☐ Low ☐ Moderate ☐ High

15. **Do you have sleep disturbances or sleep apnoea?** ☐ No ☐ Yes

Section 4: Current Symptoms & Concerns

16. **Are you currently experiencing any of the following symptoms?** *(Check all that apply)*

☐ Chest pain or discomfort
☐ Shortness of breath with activity or at rest
☐ Swelling in legs, ankles, or feet
☐ Fatigue or weakness
☐ Dizziness, light headedness, or fainting
☐ Rapid, slow, or irregular heartbeats
☐ Other: _____

17. **What is your primary reason for undergoing heart sonography today?**

18. **Do you have any additional concerns about your heart health?**

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Consent for Research Use of Anonymised Data

We are committed to advancing medical research while respecting your privacy. We may use the results of your Echo to contribute to preventative cardiac health care and cancer research advancements. Please note that:
• **Your name and personal identifiers (such as surname, ID, or any identifying details) will NOT be used.**
• **The data will be completely anonymized and used solely for research purposes to improve medical knowledge and patient care.**

Do you consent to the use of your anonymized results for medical research?

☐ **Yes, I consent**
☐ **No, I do not consent**

PRIVACY INFORMATION AND CONSENT FORM

PRIVACY ACT

The Privacy Act 1998 gives you certain rights in relation to the information you give to this medical practice. We require your consent to collect personal information about yourself. Your presence here implies you consent to us knowing about your health situation for this presentation and care. This form explains what your rights are over the use we make of the information and how we disclose it to other allied medical professionals. We acknowledge the information we ask may be deeply personal, however, not having it will restrict our capacity to provide you with the standard of medical care you expect. Please read the following information carefully and then sign where indicated below. This form and the details you supply will go on your file. Please inform us if there are any changes to these details.

This medical practice collects information for the primary purpose of providing quality health care. We require your personal details and full medical history to properly assess, diagnose, and treat your medical conditions. The information will also be used in the following ways:
• Administration of this practice, including compliance with Medicare and Health Insurance Commission Requirements.
• Disclosure to others involved with your health care, including your treating healthcare professionals outside this practice. This may involve referral/consultation to other specialists or pathologists.
• Disclosure to others for Medical Defence purposes if necessary.
• Disclosure to locums when attached to this practice for the purpose of continuing patient care.
• Disclosure to registrars, in a de-identified form for special or educational purposes. This involves photographic material and test results.
• Disclosure for research, medical students, and quality activities to improve individual and community healthcare and practice management. PATIENT CONSENT

I have read this form and understand why collecting information about me is necessary. I am also aware this practice has a privacy policy on handling patient information. I understand that I am not obliged to provide any information requested of me. I also understand that failure to provide this medical practice with all the information it needs may restrict the practice's ability to provide the quality of health care and treatment I want.

I consent to the handling of any information by this practice for the purpose set out above, subject to any limitations on access or disclosure about which I notify this practice now or in the future. I acknowledge I have read this form prior to signing and that a staff member has, at my request, clarified any aspect of it that I do not understand.

Patient Acknowledgment

I acknowledge that the above information is accurate to the best of my knowledge.

Patient Signature: _____

Date: _____