CoreCardiology
DIAGNOSTICS & TREATMENT CENTRE

Oakville Health Centre
215-1060 Speers Road, Oakville, ON, L6L 2X4
Office 905-842-6084 | **Fax** 905-842-4579
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Name: _____ **Age:** _____ **Date:** _____

Weight (kg): _____ **Height (metres):** _____ **BMI =** _____ (we will calculate)

Since your last visit, have you experienced any more of the following?

Chest Pain: Yes/No

Shortness of Breath: Yes/No

Palpitations (heart fluttering/pounding): Yes/No

Dizziness: Yes/No

Fainting: Yes/No

Gasping for air in the middle of the night? Yes/No

Have you been diagnosed with any NEW health issues since your last visit?

Current Medications:

Name of Medication	Dose (mg)	How many times daily?

Please list any medication allergies (these cause airway closure, hives, or rash):