

20240301 FOI ref 736-2324 RAPID ACCESS CHEST PAIN CLINIC

Patient Details (affix label here if you have one)		Date: Time: Seen by:	
Occupation:		Age:	CAD Score:
PAIN HISTORY: Site: Central <input type="checkbox"/> Retrosternal <input type="checkbox"/> Epigastric <input type="checkbox"/> Right-sided <input type="checkbox"/> Left-sided <input type="checkbox"/>		Radiation: Right arm <input type="checkbox"/> Left arm <input type="checkbox"/> Jaw <input type="checkbox"/> Back <input type="checkbox"/> Epigastric <input type="checkbox"/> Shoulder <input type="checkbox"/> Other <input type="checkbox"/>	
Characteristics: Dull <input type="checkbox"/> Heavy <input type="checkbox"/> Crushing <input type="checkbox"/> Tight <input type="checkbox"/> Ache <input type="checkbox"/> Stabbing <input type="checkbox"/> Discomfort other <input type="checkbox"/> Other <input type="checkbox"/>		Associated Symptoms: Dyspnoea <input type="checkbox"/> Sweating <input type="checkbox"/> Nausea <input type="checkbox"/> Palpitations <input type="checkbox"/> Dizzy/lightheaded <input type="checkbox"/> Other <input type="checkbox"/>	
		Onset: At rest <input type="checkbox"/> Crescendo <input type="checkbox"/> On exertion <input type="checkbox"/> Frequency: Duration: <input type="checkbox"/> GTN effect: None <input type="checkbox"/> Partial <input type="checkbox"/> Full <input type="checkbox"/>	
FACTORS: Precipitating:		Aggravating:	
		Relieving:	

History

Exercise Tolerance:

PAST MEDICAL HISTORY:

ALLERGIES:

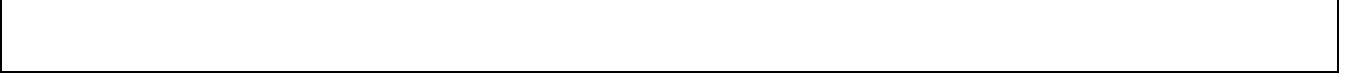
CURRENT DRUG THERAPY:

DRUG	DOSE	DRUG	DOSE

RISK FACTORS:

Smoking		Hypertension	<input type="checkbox"/>	Alcohol			
Current	<input type="checkbox"/>	Hypercholesterolaemia	<input type="checkbox"/>	Never	<input type="checkbox"/>	None	<input type="checkbox"/>
Quantity.....				Quantity			
Quit	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>		
When.....		IDDM	<input type="checkbox"/>	Never	<input type="checkbox"/>	None	<input type="checkbox"/>
Never	<input type="checkbox"/>	NIDDM	<input type="checkbox"/>	Quantity	<input type="checkbox"/>		
		Diet	<input type="checkbox"/>				

FAMILY HISTORY:



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CLINICAL EXAMINATION:							
Height:		Weight:		BMI:			
Radial Pulse:		Blood Pressure:		Respiratory Rate:			
Heart Sounds: Normal <input type="checkbox"/>		Murmur Yes <input type="checkbox"/> No <input type="checkbox"/>		Wheeze: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Abnormal <input type="checkbox"/>		Systolic <input type="checkbox"/>		Crackles: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Added Sounds Yes <input type="checkbox"/> No <input type="checkbox"/>		Diastolic <input type="checkbox"/>		Ankle Oedema: Yes <input type="checkbox"/> No <input type="checkbox"/>			
PHYSICAL EXAMINATION:							
ECG:							
BLOODS Yes <input type="checkbox"/> No <input type="checkbox"/>							
Sodium		Hb		Chol Fasting		TSH	
Potassium		WCC		Triglycerides		Free Thyroxine	
Creatinine		Platelets		HDL		Alk Phos	
Urea				LDL		Bilirubin	
				Total Chol/LDL ratio		Asp Trans	
						GGT	
						Albumin	
ETT Requested: Yes <input type="checkbox"/> No <input type="checkbox"/>				Result			
CXR: Yes <input type="checkbox"/> No <input type="checkbox"/>				ECHO: Yes <input type="checkbox"/> No <input type="checkbox"/>			
OTHER INVESTIGATIONS:							
INFORMATION GIVEN PRIOR TO DISCHARGE:							
DRUGS PRESCRIBED PRIOR RO DISCHARGE:							
DRUG		DOSE		DRUG		DOSE	
Impression and Recommendations:							

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