PATIENT INFORMATION FORM

Title: ○ Mr ○ Mrs ○ Ms

First Name: ________________________

Second Name: ________________________

SURNAME: ________________________

Address: ____

Suburb: ______________________________ **Postcode:** _________

RISK FACTORS: YES NO

	YES	NO
Have you ever smoked:	☐ Yes	☐ No
Have your parents or siblings had a heart attack:	☐ Yes	☐ No
Do you take Cholesterol medication:	☐ Yes	☐ No
Do you take Blood Pressure medication:	☐ Yes	☐ No
Do you have Diabetes:	☐ Yes	☐ No

<table>
<tr><td>Title:
○ Mr ○ Mrs ○ Ms</td><td>SURNAME:</td></tr>
<tr><td>First Name:</td><td>Second Name:</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td>Suburb:</td><td>Postcode:</td></tr>
<tr><td>GP Name:</td><td>GP Location:</td></tr>
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