

Christopher Neil

Dr Christopher Neil

Personal Information

Mr

Trevor

John

Jarvis

Trevor

0418223414

Ph: Home

Ph: Work

trevor.jarvis16@gmail.com

05/02/1968

62 Fullarton Drive

Paynesville

Victoria

Australia

3880

Managing Director of a Cartage Contracting
Company

Male

Female

Other

Emergency contact

Katrina

Jarvis

0408216307

Wife

Referral source

How did you hear about this clinic?

Social Media

Health History

If you have a history of any of the following conditions, please select below.

- ☐ Myocardial infarction (heart attack)
- ☐ Myocarditis or pericarditis
- ☒ Atrial fibrillation or other arrhythmia
- ☒ Heart failure or cardiomyopathy
- ☐ Postural Orthostatic Tachycardia Syndrome (POTS) or hypotension
- ☒ Hypertension
- ☐ Hypercholesterolaemia or lipid disorder
- ☐ Diabetes or insulin resistance
- ☐ Sleep apnoea
- ☐ Stroke
- ☐ Asthma or other lung disease
- ☒ Headaches or brain fog
- ☒ Fatigue or poor endurance
- ☒ Lightheadedness or collapse
- ☐ Skin conditions
- ☐ Bleeding or easy bruising
- ☐ Fevers or night sweats
- ☐ Weight loss or gain
- ☐ Autoimmune problems
- ☐ Epilepsy or seizures
- ☒ Numbness or nerve problems
- ☐ Vision or hearing problems
- ☐ Hormone or thyroid problems
- ☒ Urinary or prostate problems
- ☐ Dental or gum problems
- ☐ Cancer

Health condition details

If you answered yes to any of the above questions, or if you wish to provide additional background, please provide further information here.

Familiar cardiomyopathy,
I have an ICD, My father
passed away 8 years ago
of Cardiomyopathy and
arrhythmias

Surgeries and procedures

Please list any surgeries or procedures you have had, with dates and places if possible.

Gall bladder removed 2
Melanoma removed 2
cardio versions 1 Ablation
2 ICD's

Medications and supplements

Please list any medications or supplements, including the reasons you are taking them.

Solavert- Arrhythmias
Coralan5mg Candesan
32mg Paradaxa150mg
Betahistine- Menieres
Dytrex 60 - Back pain and
nerve pain. Turmeric- pain
killer Calcium plus vitamin
D - Dish disease

Vaccination history

Please list any vaccinations with dates if possible and reactions as applicable.

I can't recall having any
vaccinations in the last 15
years.

Allergies or adverse drug reactions (ADRs)

Please list any allergies to medications or other exposures.

Amioderone-
hallucinations

Alcohol and smoking

How much alcohol do you consume on a weekly basis? Do you smoke? When did you start and how often do you smoke? Other drugs use can be disclosed here.

No alcohol in 3 years
Started smoking at 19
years old finished at 22
years of age

Exercise

What type of exercise do you do and how often?

No structured exercises. I
do at least 10,000 steps
per day

Family history

Please list any conditions that run in your family.

Cardiomyopathy
Arrhythmias Liver issues
AnxietyCardiomyopathy
Arrhythmias Liver issues
AnxietyCardiomyopathy
Arrhythmias Liver issues
Anxiety

Current Complaint

What is the reason for seeking telehealth consultation with Dr Neil?

Cardiomyopathy

When did the problem begin? What caused the problem?

Mid thirties

What relieves your symptoms? What aggravates your symptoms?

Medication Stress

Have you consulted other health professionals about this problem? Please provide details and dates if possible.

Cardiologists for 20 years

Please answer the following

Do you have a GP referral?

☒ Yes ☐ No

Are you seeking a medicolegal opinion?

☐ Yes ☒ No

Are you interested to participate in research?

☒ Yes ☐ No

Have you had investigations or disease screening?

☒ Blood cholesterol or glucose measurements

☒ Electrocardiography (ECG)

☒ Holter monitor (24-hour ECG)

☒ Cardiac ultrasound (echocardiography)

☒ Cardiac magnetic resonance imaging (MRI)

☐ Exercise stress ECG/echo testing

☐ Nuclear stress testing

☒ Prostate Specific Antigen (PSA test) and examination

☐ Faecal occult blood test or colonoscopy

☐ Mammography

☐ Pap smears

Pain scale

On a scale of 1-10 with 1 being minimal and 10 being maximum pain, how would you rate your pain?

1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Mood scale

On a scale of 1-10 with 1 feeling very down and 10 feeling great, how would you rate your mood?

1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Sleep quality scale

On a scale of 1-10 with 1 being very poor and 10 being excellent, how would you rate your sleep quality?

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|----------------------------------|-----------------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Energy scale

On a scale of 1-10 with 1 being very low energy and 10 being very energetic, how would you rate your energy?

- | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input checked="" type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

List of test results

Medicare 3243493882

Treatment consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and I give my full consent to telehealth consultation and treatment. I intend this consent to apply to all future treatments and I understand that I must update my service provider with any changes that may occur in my medical history. I understand that a cancellation fee may apply if I do not provide at least 24 hours notice.

☒ I consent to telehealth consultation and treatment

☒ I consent to receiving SMS and/or email updates, news & offers

Client Name *

Date

Trevor John Jarvis

17/07/2024

☒ I am the client

☐ I am submitting on behalf of the client