Christopher Neil

Dr Christopher Neil

Personal Information

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Emergency contact

Grace	Kearney
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Referral source

How did you hear about this clinic?

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.	Developed pericarditis and arrhythmia within days of first and only pfizer vaccine in October 2021. They have both been constant/incessant since.

Surgeries and procedures

Please list any surgeries or procedures you have had, with dates and places if possible.	Tonsillectomy and appendectomy approx 1996/87. Caesarian birth 2007.

Medications and supplements

Please list any medications or supplements, including the reasons you are taking them.	Deralin and low rise contraceptive pill for migraine prevention and hypertension. Colchicine twice daily for pericarditis. Aspirin twice daily to mitigate stroke risk from pill, and also assists with the pericarditis. Magnesium for muscle relaxation. Vitamin D due to diagnosed deficiency.

Vaccination history

Please list any vaccinations with dates if possible and reactions as applicable.	Flu vax most years - mild flu like reaction. Pfizer vaccine in Oct 2021, felt ill/numb fingers and toes /chest pain and constriction / giddy / nausea and fatigue

Allergies or adverse drug reactions (ADRs)

Please list any allergies to medications or other exposures.	Adverse reaction sulphites, latex, MSG, shellfish.

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.	Nil alcohol, non smoker, no other drugs.

Exercise

What type of exercise do you do and how often?	Regular 30 minute walks and 10 minutes weights, 3-5 time per week when pericarditis is under control.

Family history

Please list any conditions that run in your family.	Tachycardia/ pacemaker - sister Valve transplant and arrhythmia- father

Current Complaint

What is the reason for seeking telehealth consultation with Dr Neil?	No success so far getting help with pericarditis or arrhythmia from Pfizer vaccine. It has negatively impacted every are often my life.
When did the problem begin? What caused the problem?	Pfizer vax October 2021.
What relieves your symptoms? What aggravates your symptoms?	Aggravated by strenuous or prolonged exercise, which I used to be able to do, or by stress or lifting anything heavy, or walking up incline. Only relief is to stop all physical activity sometimes for weeks at a time, or if severe flare up, course of prednisone and bed rest.
Have you consulted other health professionals about this problem? Please provide details and dates if possible.	I've tried 3 other cardiologists who were dismissive and didn't feel it was likely caused by the Pfizer vaccine, even though the symptoms onset within hours. Happy to discuss further at consult. Only support has been my long term GP who has been extremely supportive.

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
○	○	○	○	○	○	◉	○	○	○

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
○	○	○	◉	○	○	○	○	○	○

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
○	○	○	◉	○	○	○	○	○	○

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
○	○	◉	○	○	○	○	○	○	○

List of test results

Medicare 4371276973

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 *

Jane Kearney

Date

16/07/2024

☑ I am the client

☐ I am submitting on behalf of the client