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MAIN MEMBER INFORMATION:

ID NUMBER: _____ SURNAME: _____
FULL NAMES: _____
INITIALS: _____ GENDER: MALE/FEMALE
HOME LANGUAGE: _____TITLE: _____ DATE OF BIRTH: _____
CELL NUMBER: _____ HOME NUMBER: _____
WORK NUMBER: _____ EMPLOYER: _____
EMAIL ADDRESS: _____ EMAIL STATEMENTS: YES/NO
POSTAL ADDRESS:
_____
_____ POSTAL CODE: _____
PHYSICAL ADDRESS:
_____
_____ POSTAL CODE: _____
MEDICAL SCHEME: _____
PLAN/OPTION: _____
MEMBER NUMBER: _____ DEPENDANT CODE: _____
GAP COVER: YES/NO DETAILS/PLAN/NUMBER: _____

PATIENT INFORMATION:

ID NUMBER: _____ SURNAME: _____
FULL NAMES: _____
INITIALS: _____ GENDER: _____TITLE: _____ DATE OF BIRTH: _____
CELL NUMBER: _____ USE THIS NR FOR APPOINTMENTS: Y/N
(MAIN MEMBER'S CELL PHONE NUMBER WILL BE USED IF ABOVE IS NO)
HOME NUMBER: _____
WORK NUMBER: _____ EMPLOYER: _____
EMAIL ADDRESS: _____
TYPE OF DEPENDANT: ***MAIN MEMBER/SON/SPOUSE/DAUGHTER/MOTHER/FATHER/OTHER***
DEPENDANT CODE: _____
HEIGHT(M): _____ WEIGHT(KG): _____
REFERRING DOCTOR: _____
ICD-10 CODE(S): _____

NEXT OF KIN:

SURNAME: _____
FULL NAMES: _____
INITIALS: _____ TITLE: _____
CONTACT NUMBER: _____RELATIONSHIP_____

MEDICAL QUESTIONNAIRE:

DO YOU SMOKE? HOW MANY/DAY & HOW MANY YEARS: _____
ARE YOU PREGNANT PRESENTLY? HOW MANY WEEKS? _____
PROFESSION: _____ HAND DOMINANCE: LEFT/RIGHT

MEDICAL HISTORY: *(PLEASE ANSWER YES/NO TO THE FOLLOWING AND IF YES PLEASE GIVE DETAILS)*
HYPERTENSION: _____
LUNG DISEASE (ASTHMA, EMPHYSEMA): _____
DIABETES (TYPE 1 OR 2): _____
HEART OR BLOOD VESSEL DISEASE? STENTS? _____
PREVIOUS THROMBOSIS / EMBOLISM? WHERE? _____
KIDNEY OR BLADDER DISEASE? _____
JAUNDICE OR HEPATITIS (IF SO, WHEN?) _____
EPILEPTIC CONVULSIONS? _____
MUSCLE DISEASE OR STROKE? _____
THYROID DISEASE? _____
HIV POSITIVE? WHICH TREATMENT? _____
HERPES SIMPLEX INFECTION (FEVER BLISTER)? _____
ALLERGIC TO IODINE, PENICILLIN, LATEX OR ANY OTHER MEDICATION?
_____
PLEASE LIST ALL YOUR CHRONIC MEDICATION:
_____
_____
_____

DO YOU USE ANY OF THE FOLLOWING AND IF YES PLEASE GIVE DETAILS?
1. CONTRACEPTIVE? _____
2. HERBS & VITAMIN SUPPLEMENTS? _____
3. CORTISONE, PLAVIX, CLOPIDOGREL, CLOPIWIN, WARFARIN, XARELTO, PRADAXA, GRANDPA, DISPRIN, ASPIRIN, VOLTAREN, NUROFEN OR BRUFEN?
_____
4. ROACCUTANE / ORATANE? _____

SURGICAL HISTORY:
PLEASE LIST YOUR PREVIOUS OPERATIONS, DATES & COMPLICATIONS:
_____
_____
_____

BREAST & ABDOMINAL SURGERY QUESTIONNAIRE: *(ONLY FILL IF APPLICABLE)*
AMOUNT OF PREGNANCIES? _____ NUMBER OF CHILDREN? _____
BREAST FEEDING? _____ PRESENT BRA SIZE? _____
FAMILY HISTORY OF BREAST CANCER? MOTHER/SISTER/FATHER/BROTHER _____
ABDOMINAL OR UMBILICAL HERNIAS? _____
MAMMOGRAM/SONAR & DATE? _____