PATIENT INFORMATION SHEET

☎ TEL: Business: _____ Cell:_____

Home: _____ Email: _____

SURNAME _____ NAME _____

DATE OF BIRTH_____ OCCUPATION _____

ID NUMBER _____

ADDRESS _____

._____

MEDICAL AID NAME _____

MEDICAL AID NUMBER _____

MEMBER'S NAME _____

MEDICAL DOCTOR _____

REFFERED BY _____

NEAREST FAMILY/FRIEND Name:_____ Relationship:_____

Address: _____ Tel: _____

MEDICAL HISTORY (tick ✔ where applicable)

❑ Allergies_____ ❑ Operations_____

❑ Accidents_____ ❑ Medication_____

❑ HIV Positive_____

Is there a family history of : ❑ Cancer? _____ ❑ Diabetes?

❑ High Blood Pressure? ❑ Heart Disease?

Do you smoke? _____ How many per day? _____

DO YOU HAVE : ❑ Headaches? ❑ Neck pain & stiffness ❑ Shoulder Pain

❑ Elbow or Hand Pain ❑ Lower back pain ❑ Leg Pain

❑ Knee Pain ❑ Foot Pain ❑ Weakness

❑ Numbness ❑ High blood pressure ❑ Blurring of vision

❑ Chest pains ❑ Diabetes ❑ Cancer

❑ Pregnant ❑ Heartburn ❑ Hot flushes

❑ Osteoporosis ❑ Ankle Pain ❑ Hip Pain

☺☺ THANK YOU ☺☺