MEDICAL HISTORY

Full Name: _____

Preferred Name: _____

Date of Birth: _____

Contact Number: _____

E-mail address: _____

Name of GP and/or referring doctor: _____

Medical Aid Name: _____

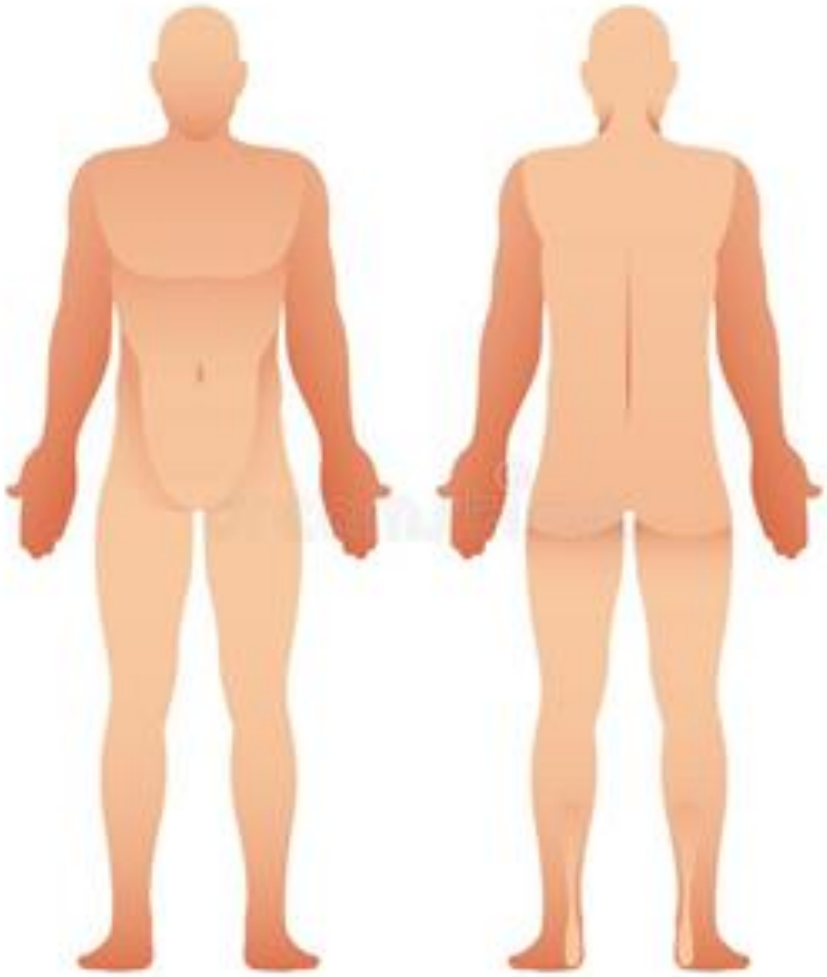
Medical Aid Number: _____

Medical Aid Plan: _____

Gap Cover: **Y/N**

1. **Main complaint: Please describe your symptoms and reson for the consultation request (be as complete as possible):**

2. Please indicate site of symptoms:



3. How long have you experienced this problem?

4. **Please list medication allergies:**

5. **Please tick if applicable:**

History of cancer	☐
Unexplained weight loss	☐
Recent infection	☐
Recent change in bowel control	☐
Recent change in bladder control	☐
Loss of sensation on inner thighs	☐
Recent injuries	☐
Fever/Chills/Night sweats	☐
Immune system problems	☐
Intravenous drug use	☐
Pain worse on lying down	☐
Pain worst at night	☐

6. **Weight:** _____

7. **Height:** _____

8. **Smoking Status**: Never Smoked/Stopped smoking/Current Smoker

9. **Is your condition related to an injury at work?** Yes/No

10. **Are you considering any legal actions?** Yes/No

11. Please list all prescription medication you are taking:

12. Please list any over the counter/homeopathic medication you are taking:

13. Please list all medication for pain relief:

14. Did you try any off the following for pain relief?

None	Injections	Biokineticist	Chiropractor	Pain Clinic
Dorsal column stimulator	Rhizotomy	Facet Cortizone or Blocks	Intracthecal Drug Infusion Pump	Physiotherapy

15. PREVIOUS OPERATIONS

Did you undergo any previous operations?	Yes	No

Type of Surgery	Date of Surgery	Surgery or Anaesthesia related Complications

16. RISK FACTORS

Were you ever diagnosed with Cancer? Yes No	Type of cancer:	
Treatment: Surgery	Chemotheraphy	Radiotheraphy

Do you have a history of Heart Failure?	Yes	No	Unknown
Describe treatement:			

Do you have any of the following risk factors for Excessive Bleeding:

Bleeding History	Blood thinning medication (Anticoagulants/antiplatelet medications)	
Easy bruising	Bone marrow, liver or renal failure	None

Do you have any of the following risk factors for infections?

Recent bloodstream infection	Type 1 (Insulin-dependent) Diabetes	
Steroid or Cortizone Chromic medication	Type 2 (Adult-onset) Diabetes	None

Do you have any of the following Renal risk factors?

Angiotensin-converting anzyme inhibitor (ACE inh) or Angiotensin II receptor blocker (ARB) Medication for Hypertension		
Dialysis treatment	Diuretics (Water pills)	Acute renal failure (ARF)
Anti-inflammatories (NSAIDS)	Chronic renal failure (CRF)	None

Do you have any of the following Respiratory risk factors?

Chronic obstructive pulmonary diseasa (COPD)	Currently Smoking	None

Do you experience shortness of breath?

With moderate exertion	With mild exertion	At rest	None

Do you have any of the following risks for Blood clot formation?

Oral estrogen-based medication (contraceptives or hormone replacement)		
Current smoker	Not moving for long periods	Cancer
Recent surgery	Obesity	None
Previous Deep Vein Thrombosis (blood clot in a deep vein)		Pregnancy

17. FUNCTIONAL STATUS		
How would you describe your functional status?		
Independent	Partially dependent	Totally dependent

18. SPECIAL INVESTIGATIONS	
Have you had any special test (XR/MRI/etc) done to further investigate your complaints? (Please also remember to bring them along for your consultation) Yes No	
Investigation (eg: MRI)	Date

Do you have any of the following contraindications for undergoing an MRI?		
Cochlear Implants	Deep Brain Stimulator	Implanted Defibrillator
Ferromagnetic aneurysm clip	Kidney Disease	Metallic Foreign Bodies
Pacemaker	Pregnancy	None

19. OTHER SPECIALIST OPINIONS	
Have you seen any other doctors regarding the same problem? Yes No	
Name of doctor	Date of evaluation

20. HAVE WE COVERED EVERYTHING?
Please enter any other information about our health that you would like me to know or address:

Please continue questionaire on next page...

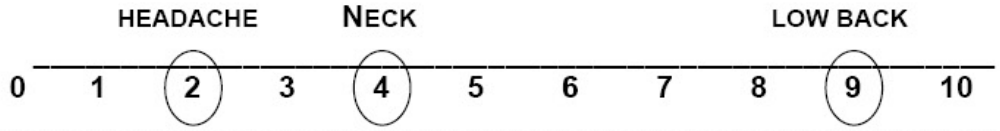
QUADRUPLE VISUAL ANALOG

Name _____ Number _____ Date _____

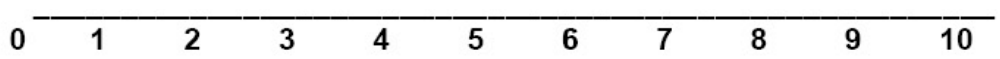
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

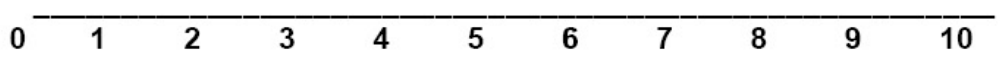
EXAMPLE:



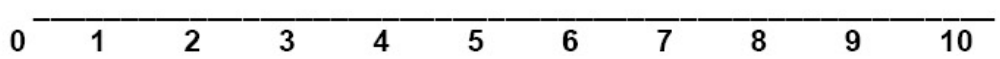
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

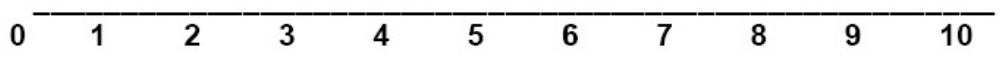


3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

If you experience neck or back pain please also complete the **Neck Disability Index** and/or the **Owestry Low Back Pain Index**.

DECLARATION

I,_____(Patient's full name) have completed this form with due diligence and understand that Dr Swart will use the information supplied by me to assist him in my treatment. Furthermore, I hereby permit that my clinical and surgical notes may be sent to my referring doctor, other specialists on my treatment team, representatives of medical supply companies, my medical aid and insurance company. I authorise Dr Swart to use my anonymised clinical data for research purposes, when needed.

Signature: _____ Date: _____