PATIENT'S MEDICAL HISTORY

Full name & Surname: Preferred Name:

Prof/Dr/Mr/Mrs/Miss/Me: Preferred Pronoun: he/she/they

Date of Birth: Occupation:

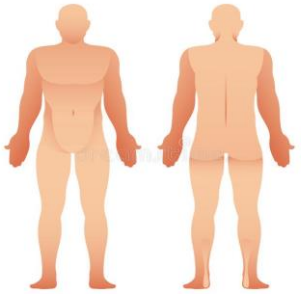
In which town/city do you stay:

Name of GP and referring doctor:

Medical Aid name & plan: Gap Cover Y/N

Please describe your symptoms / reason for the consultation request (be as complete as possible):

Indicate location of symptoms: of your symptoms:



Please list **medication allergies**:

Past **surgical operations**, please specify approximate dates and surgeons involved:

List all **medications**, including painkillers (analgesics) previously and currently used.

Please list previous **specialists**, specifically list all spine/brain surgeons:

Please also specify which ones failed to work:

Have any **special investigations** like x-rays, blood tests or MRI/CT scans been done? Please specify:

(Please indicate where and when the investigations were done)

On a scale of 0-10 (10 = worst)

Pain **RIGHT NOW**:

AVERAGE Pain:

Pain at its **BEST** :

Pain at its **WORST** :

What is your weight (kg):

What is your length (m):

Is your condition related to an injury on duty: Y/N

Have you been for:

Physiotherapy	☐
Chiropractic	☐
Pain clinic	☐
Biokinetic treatment	☐
Injections	☐
Rhizotomies	☐

List **ongoing medical problems** and major illnesses like asthma, diabetes, hypertension, immune system depression etc.

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 inner thighs	☐
Recent injuries	☐
Fever/Chills/night sweats	☐
Immune system problems	☐
Intravenous drug use	☐
Pain worse on lying down	☐
Pain worst at night	☐

Please tick if applicable:

History of heart failure	☐
Any history of excessive bleeding	☐
Using blood thinners	☐
Kidney failure	☐
Chronic lung disease	☐
History of blood clots	☐