HEALTH QUESTIONNAIRE

SURNAME: _____

FULL NAMES: _____

NICKNAME: _____

DEPENDANT CODE: _____

BIRTH DATE: _____

TEL. NO: _____

GENERAL HEALTH

GOOD ☐ FAIR ☐ BAD ☐

Are you currently seeing a specialist? YES ☐ NO ☐

If Yes, supply details:

_____

_____

Mark applicable blocks with an X

Weight Loss		Infections	
Sinus Problems		Kidney Disease	
Diabetes		Glaucoma	
Porphyria		Epilepsy	
Stroke		Arthritis	
Psyciatric Care			

LIVER DISORDERS

Hepatitis / Jaundice ☐ Year: _____

HEART CONDITIONS

Congenital Heart Lesions	
Rheumatic Fever	
Valve Prosthesis	
Heart Murmer	
Cardiac Pacemaker	

Year: _____

VASCULAR CONDITIONS

High Blood Pressure	
Low Blood Pressure	
Bleeding Tendancy	
Blood Clotting Disorders	

LUNG CONDITIONS

Asthma	
Tuberculosis	

HIV/AIDS

High risk group? YES ☐ NO ☐

Do you have any disease, condition or problem not listed above that you feel we should know about? YES ☐ NO ☐

Please supply details:

_____

_____

MEDICATION

Mark applicable blocks with an X

		Name:
Anti-depressants		
Tranquilizers		
Cortizone		
Blood Thinners		

Apart from the above, do you use any other medication?

YES ☐ NO ☐

If Yes, please list them:

_____

_____

ALLERGIES

Please list:

_____

_____

FEMALE PATIENTS

Are you pregnant? YES ☐ NO ☐ _____ Number of Weeks

Do you use the pil? YES ☐ NO ☐

With this I declare that all the above details are correct.

_____

Signature

_____

Date