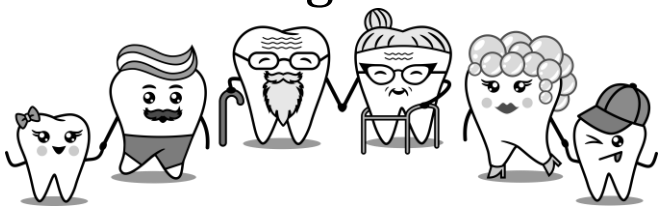
Dr Ivana Bugwandeen Inc



BChD (UP) • Pr 0914576

Tel: 031 207 1557 | 066 365 6784
Email: drivanabugwandeen@gmail.com

Shop 2, 33 Overport Drive, Durban, 4091
www.drivanabugwandeen.com

GENERAL PATIENT INFORMATION & MEDICAL QUESTIONNAIRE

Title	MR/ MRS/ Miss/ Dr/ Prof/ Other	
Surname		
First Name/s		
Date of Birth		
RSA ID #		
Residential Address		
	Postal code	
Postal Address		
	Postal code	
Telephone	(H) (W)	
Cellphone		
Email address		

The address (physical/postal/e-mail) provided shall be used for as your chosen *domicilium citandi et executandi* at which legal notices and processes can be served on you. You will be deemed to have received a legal notice or document if delivered to that address, whether or not you actually receive it. Therefore, please inform us, in writing, of any changes to these details.

Medical Aid Name			**Scheme**	
Medical Aid Number				
Emergency contact	**Name**		**Tel.**	
Details of GP	**Name**		**Tel.**	
Details of specialist	**Name**		**Tel.**	

Gender	**MALE**	**FEMALE**		
Are you currently pregnant?	**YES**	**NO**	**If yes, weeks**	

Are you currently taking any medication?	**YES**	**NO**

Please list below the medication which you are currently taking:

NAME	STRENGTH	FREQUENCY

ALLERGIES: Please name any medication or drugs to which you have had an allergic response:	

Have you ever had any of the following disease/s or medical conditions?						
Alcohol Abuse	YES	NO		Heart attack	YES	NO
Alzheimers Disease	YES	NO		Heart murmur	YES	NO
Anaemia	YES	NO		Heart surgery	YES	NO
Arthritis	YES	NO		Hepatitis A/B/C	YES	NO
Artificial bones/joints/valves	YES	NO		Herpes	YES	NO
Asthma	YES	NO		High Blood Pressure	YES	NO
Bleeding disorder (Haemophilia)	YES	NO		Low Blood Pressure	YES	NO
Blood Transfusion	YES	NO		Kidney Problems	YES	NO
Bronchitis	YES	NO		Mitral Valve Prolapse	YES	NO
Cancer	YES	NO		Pacemaker	YES	NO
Chemotherapy	YES	NO		Parkinsons Disease	YES	NO
Congenital Heart Failure	YES	NO		Psychiatric Problems	YES	NO
Diabetes Type 1	YES	NO		Radiation Treatment	YES	NO
Diabetes Type 2	YES	NO		Rheumatic Fever	YES	NO
Difficulty Breathing	YES	NO		Seizures	YES	NO
Dizziness/Fainting spells	YES	NO		Sexually transmitted diseases	YES	NO
Drug/Alcohol abuse	YES	NO		Shingles	YES	NO
Emphysema	YES	NO		Sinusitis	YES	NO
Epilepsy	YES	NO		Stroke	YES	NO
Fever blisters	YES	NO		Tuberculosis	YES	NO
Glaucoma	YES	NO		Ulcers	YES	NO

Please specify any disease, condition or problem not listed above	
Have you been hospitalised in the last 2 years?	

Patient signature:	Date:
Self/ Parent/ Guardian	Patients File Number:

Please assist in telling us how you found us?

Google ☐ Facebook ☐ Word-of -mouth ☐ Pamphlets ☐ Islam Alive ☐

Signage (walking/driving-by) ☐ Other ☐ _____