PATIENT INFORMATION & MEDICAL HISTORY

dr.schalkburger

Neurosurgeon MBChB, FCS (SA)

Specialist neurosurgeon performing Cranial, Spinal, Peripheral Nerve and Pain Procedures

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PASIENTBESONDERHEDE | PATIENT DETAIL

Van | Surname:	Noemnaam | Nickname:

Title: Master	Mr	Miss	Mrs	Ms	Mx	M	Dr	Prof	Other:

Naam | Name:	Geboortedatum | Birth Date:

Huwelikstatus | Marital Status: Single	Married	Separated	Divorced	Widowed

Beroep | Occupation:	Geslag | Gender:
ID no:	Huistaal | Home Language:
Tel (H):	Selfoon | Mobile:
e-pos | email:	
Medies Ongeskik | Medically Boarded: Yes No	Datum | Date (if applicable):

PERSOON VERANTWOORDELIK VIR REKENING | ACCOUNT RESPONSIBILITY

Van | Surname:	Naam | Name:
Posadres | Postal Address:	
Fisiese Adres | Physical Address:	
Werkgewer | Employer:	Kode | Code:
Tel (W):	Selfoon | Mobile:

VERWANTE PERSOON | NEXT OF KIN

Van | Surname:	Naam | Name:
Adress | Adres:	Kode | Code:
Tel (W):	Selfoon | Mobile:

MEDIESE FONDS | MEDICAL FUND

Hooflid | Main Member:	
Naam | Name:	Opsie | Plan:
Dep Code:	No:

GAP COVER | KORTING DEKKING

Do you have Gap Cover?	Yes No	Company | Nr:

VERWYS DEUR | REFERED BY

Naam | Name:	GP:
Tel (H):	E-pos | Email:

Datum | Date:	Geteken: Sign:

Die rekening wat ek ontvang is my, die ondergetekende, se verantwoordelikheid en sal deur my of my mediese fonds vereffen word. Rente prima 2% word gehef op 30 dae uitstaande rekening. Indien enige invorderings/regsonkostes ontstaan om uitstaande bedrae te vorder, aanvaar ek volle aanspreeklikheid. Ek onderneem verder om die praktyk te verwittig van enige adresverandering.

Appointment Date:

MEDICAL HISTORY

BIOMETRICS:

Weight (kg):	Height (m):
Calculated BMI:	

HABITS

What is your smoking Status:	Never smoked	Stopped smoking		Months ago	Currently Smoking

How many Cigarettes do/did you smoke per day?
For how many years have/did you smoke?

How many times per week, on average, do you drink alcoholic drinks?		How many alcoholic drinks, on average, do you drink per occasion?	

ALLERGIES

Do you have any allergies?	None	Unknown	Anticonvulsants	Chemotherapy drugs	Iodine
	Nonsteroidal anti-inflammatory drugs	Local Anaesthetics	Penicillin	Sulfa Drugs	Aspirin
	Others (Specify):				

MEDICO-LEGAL

Is your condition related to an injury at work?	Yes	No	Are you considering any legal actions?	Yes	No

MEDICATION AND PAIN TREATMENT

Do you use any prescription medication? None List:

Name of Medication	Dose (Strength in mg)	Interval (ea. twice daily or bd)

Do you use over-the-counter medication? None or List:

Name of Medication	Dose (Strength in mg)	Interval (ea. twice daily or bd)

Do you use medication for pain relief? None or List:

Name of Medication	Dose (Strength in mg)	Interval (ea. twice daily or bd)

Did you try any of the following for pain relief?

None	Injections	Biokineticist	Chiropractor
Dorsal Column Stimulator	Rhizotomy	Facet (Cortizone) Infiltrations or Blocks	
Pain Clinic	Physiotherapist	Intrathecal Drug Infusion Pump	

PREVIOUS OPERATIONS

Did you undergo any previous operations? None or List:

Type of Surgery	Date of Surgery	Surgery or Anaesthesia related Complications

RISK FACTORS

Were you ever diagnosed with cancer?	Yes No	Type of cancer:

Treatment:	Surgery	Chemotherapy	Radiotherapy

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

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

Bleeding history	Blood-thinning medication (Anticoagulants/ Antiplatelet medications)	
Bone marrow, liver or renal failure	Easy bruising	None

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

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

Do you have any of the following Renal risk factors?

Angiotensin-converting enzyme inhibitor (ACE inh) or Angiotensin II receptor blocker (ARB) medication for Hypertension		
Dialysis Treatment	Diuretics (Water pills)	Anti-inflammatories (NSAIDS)
Acute Renal Failure (ARF)	Chronic Renal Failure (CRF)	None

Do you have any of the following Respiratory risk factors?

Chronic Obstructive Pulmonary Disease (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	Recent Surgery
Cancer	Obesity	None
Previous Deep Vein Thrombosis (blood clot in a deep vein)		Pregnancy

FUNCTIONAL STATUS

How would you describe your Functional Status?

Independent	Partially dependent	Totally dependent

SPECIAL INVESTIGATIONS

Have you had any special tests (XR/ MRI, etc.) done to further investigate your complaints? (Please also remember to bring them along for your consultation.) No / List

Investigation (ea. MRI)	Date

Do you have any of the following contraindications for undergoing an MRI?

Cochlear implant	Deep Brain Stimulator	Implanted Defibrillator
Ferromagnetic Aneurysm Clip	Kidney Disease	Metallic Foreign Bodies
Pacemaker	Pregnancy	None

OTHER SPECIALIST OPINIONS

Have you seen any other doctors regarding the same problem? No/ Elaborate

Name of doctor	Date of evaluation

MAIN COMPLAINT

Please give me a concise description of your chief complaint (ea. “burning pain down my left arm which started spontaneously 10 days ago; rather than “a pinched nerve”).

HAVE WE COVERED EVERYTHING?

Please enter any other information about your health that you would like me to know or address:

DECLARATION

I ,____(Patient’s name) have completed this form with due diligence and understand that Dr. Burger will use the information supplied by me to assist him in my treatment. Furthermore, I hereby permit that my clinical, and surgical, notes can be sent to my referring doctor, medical aid, and your insurance company. I also authorize Dr. Burger to use my anonymized clinical data for lecturing and research purposes.

Datum | Date:	Geteken: Sign: