
PRE-VISIT QUESTIONNAIRE:

All information will be treated with the utmost confidence.

Demographic information:

Is this your first visit?

Yes No

If No, what year _____

Name: _____ **Surname:** _____

Title: (circle one) Mr. Mrs. Ms. Dr. Rev.

Employer: _____ **Health Insurance Co:** _____

Type of work:

- | | |
|--|---|
| <input type="checkbox"/> Office worker | <input type="checkbox"/> Agriculture/Labourer |
| <input type="checkbox"/> Sales/marketing | <input type="checkbox"/> Equipment operator |
| <input type="checkbox"/> Managerial/administrative | <input type="checkbox"/> Factory worker |
| <input type="checkbox"/> Professional | <input type="checkbox"/> Home maker |
| <input type="checkbox"/> Teacher/Nurse | <input type="checkbox"/> Student - school |
| <input type="checkbox"/> Police officer/Soldier/Security | <input type="checkbox"/> Student - University |
| <input type="checkbox"/> Technical | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Hospitality services | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Craft/trade | |
-

Telephone: Home: _____ Work: _____ Ext: _____

Would you like to receive health tips and updates by e-mail?

Yes No If yes: **E-Mail address:** _____

Date of birth: day ___ month ___ year _____

Household: No. of persons over 17 yrs old _____

No. of persons less than 18 yrs _____

Religion: Hindu Muslim Roman Catholic Anglican Presbyterian
 Pentecostal Other Christian Other None

Marital Status: Single Married Live-in Partner
 Separated Divorced Widowed

Women only: No. of children born _____

Health information. This is intended to assist in your discussion with the doctor

Family history:

Condition	grandparent	father	mother	brother	sister	child
Diabetes						
High blood pressure						
Stroke						
Heart disease						
Glaucoma						
Cancer						

Other: _____

Personal history:**year**

Major illness: _____

Major surgery: _____

Major injury: _____

Major allergies: _____

Present health:**Tick any of the following for which you regularly seek medical attention:**

- Asthma High blood pressure Heart disease
 Diabetes Stroke Backache
 Rheumatoid arthritis Osteoarthritis Other arthritis
 Other chronic condition: _____

Current medical treatment: I am currently/frequently taking medication for:

Condition	medication	dose
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Major concerns:

- Over/under weight decreased energy/tiredness
 Stress at work stress at home anxiety/tension
 Indigestion constipation Impotence/loss of libido

Pain/discomfort: back joints abdomen
 headaches/migraine Other: _____

Health risks: Heart disease Cancer Diabetes Stroke
 Other: _____

Other concerns: _____