CAPE HIP&KNEE PRACTICE

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MBChB(UCT) FRCS(Edin) FCS Orth(SA) Mmed(UCT)

Dr. Brendan Dower
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Dr. Marc Nortje
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PATIENT DETAILS

[File Number:]

Surname: .... Name: .... Title: ....

ID Number / Date of Birth: .... Marital Status: .... Occupation: ....

Email: ....

Tel (H): .... Cell: .... (W): ....

Postal Address: .... Code: ....

Residential Address: .... Code: ....

PERSON RESPONSIBLE FOR ACCOUNT IF DIFFERENT FROM ABOVE

Surname: .... Name: .... Title: ....

ID Number / Date of Birth: .... Marital Status: .... Occupation: ....

Email: ....

Tel (H): .... Cell: .... (W): ....

Postal Address: .... Code: ....

MEDICAL AID DETAILS

Medical Aid: .... FULL COVER / HOSPITAL COVER

Medical Aid Number: .... Option: ....

NEXT OF KIN

Name: .... Telephone: ....

REFERRED BY

Name: .... Telephone: ....

GENERAL PRACTITIONER

Name: .... Telephone: ....

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MEDICAL INFORMATION

Height in cm:	Weight in kg:	BMI

SYMPTOMS

Sharp/burning pain	Dull ache	Tingling/altered sensation
Stiffness	Weakness	Swelling
Clicking/giving way		

Severity of the pain 1 (almost don't notice it) to 10 (most severe pain you have ever had)

LOCATION

Lower back	Buttock	Side of the hip
Groin/thigh	Knee	
Left	Right	Both sides

DURATION/ONSET/WHEN

More than 3 weeks	Started spontaneously	Intermittent
Constant	Wakes at night	Worse after activity

Nature of injury or name of sport

TREATMENT

Medication that helps

Any other treatments eg physio/chiro

Have you had Xrays recently and if so where?

PAST MEDICAL HISTORY

Angina or cardiac/heart problems	Blood pressure or cholesterol requiring medication
Aspirin/Warfarin or blood thinners	TB/Asthma/COPD or lung problems
Diabetes	General anaesthetic/surgery in the last year

Allergies

PLEASE NOTE

Settlement of your account is your responsibility and we kindly request settlement following your consultation, or within 30 days following any procedure. Claiming a refund from your medical aid is your responsibility.

We reserve the right to :-
a) charge interest on overdue accounts
b) refer overdue accounts to a collection agency at your expense

SIGNATURE: .... **DATE:** ....