MEDICAL HISTORY FIRST VISIT FORM

In order for us to give you the best service possible, kindly return this form no less than 48 hours prior to your appointment.

Name and Surname

Title

Gender

Date

Cellphone Number

Date of Birth

ID Number

Email Address

Referred by

Address

At RevitaHealth, we want to help you to become your best self.
Please help us by completing this form in as much detail as possible.

1. Main concerns and existing conditions
Include how long you have been experiencing the condition

2. Previous surgery and age at the time
Include all minor and major surgeries

	Age

Have you ever been admitted to hospital for any other reason than surgery? Yes No

If yes, please elaborate and mention types of doctors involved.

Have you had your blood drawn within the past 6 months? Yes No

Where did you draw blood? Ampath Pathcare Lancet Other

3. Allergies

Environmental

Medications

4. Current Medication

Please specify dosage as well as duration of use

5. Supplements

Specify any suplements, homeopathic remedies and/or natural products you are using.

6. Family History

List any medical conditions or cause of death.

Father	alive/deceased	age	
Mother	alive/deceased	age	
Sibling	alive/deceased	age	
Sibling	alive/deceased	age	
Sibling	alive/deceased	age	
Sibling	alive/deceased	age	
Sibling	alive/deceased	age	

Is there anything else regarding your family medical history that you would like to mention or are concerned about?

7. Conditions

Mark the conditions you have been diagnosed with or suspect of having. Indicate age of diagnosis.

	Anxiety	age
	Depression	age
	Chronic Fatigue	age
	Headaches	age
	Migraine	age
	Fibromyalgia	age
	Asthma	age
	Cancer	age
	Psoriasis	age
	Arthritis	age
	Eczema	age
	Hay Fever	age

	Cholesterol	age
	Cardiac Disease	age
	Diabetes	age
	Epilepsy	age
	Hypertension	age
	Hypotension	age
	Circulatory Disorder	age
	COPD	age
	Hepatitis	age
	Kidney Stones	age
	Gout	age
	Diverticulitis	age

	Lung Disease	age
	HIV	age
	Renal Disease	age
	Gallstones	age
	Chron's	age
	Ulcerative Colitis	age
	Spastic Colon	age
	Maleria	age
	Thyroid	age
	Porphyria	age
	Tick Bite Fever	age
	Other	age

If other please specify:

8. Work

What work do you currently do?

How many hours per week do you work?

Do you enjoy your work? Yes No

What work have you done in the past?

9. Dental History

Do you use a plate or grind your teeth? Yes No

Number of metal fillings/crowns

Have you ever had teeth removed? Why?

Please specify any other dental issues:

10. Body Composition

Current weight kg

Best weight ever kg

Age at best weight

Heaviest weight kg

Desired weight kg

Height cm

Have you gained/lost weight in the last 5 years? Why do you think that is?

Do you struggle with your weight? Why do you think that is?

Have you ever had an eating disorder? When and how long did it last?

11. Diet

Do you have any dietary allergies? Yes No

Please elaborate

Have you even been to a dietician? Yes No

Please elaborate

What are your nutrition goals / what do you wish to achieve from your visit?

By when would you like to reach your nutrition goals? By setting realistic goals, it will be easier for you to achieve them.

How often do you consume the following? Tick the applicable boxes	Daily	Weekly	Monthly	Never
Breakfast Cereals				
Energy/ Protein/Chocolate bars				
Vegetables (Fresh or Frozen)				
Animal protein (Beef, Ostrich, Chicken, Fish)				
Legumes (Beans, Chickpeas, Lentils,etc.)				
Fruit (Fresh or Frozen)				
Bread (White or Brown)				
Starchy vegetables (Butternut, Sweet Potato, Potato, etc.)				
Pasta				
Fresh Fish				
Tinned Fish				
Fast foods				
Ready prepared meals				
Nuts and Seeds				

Do you follow a specific diet? Vegan, Vegetarian, Keto, etc

Are there any specific foods that you don't enjoy eating?

Indicate how many units of the below you consume on a daily basis (1 unit = 250ml)

Water Filter coffee Decaf coffee Fizzy drinks Dairy

Black tea Herbal tea Energy drinks Fruit juice

How many teaspoons of sugar in your coffee/tea? Sugar Sweetner Honey

Complete the one day food journal below - be as accurate as possible

Meal	Time	What you had	Measurement (cup, spoon, etc)
Breakfast			
Brunch			
Lunch			
Snack			
Dinner			
Drinks			
Dessert			

12. Lifestyle

Marital

Married?	Yes	No
For how long?		
Previously divorced?	Yes	No
When?		

Children

Children at home?	Yes	No
Ages of Children	1st	2nd
	3rd	4th

Smoking

Do you smoke?	Yes	No
How many cigarettes per day?		
How long have you been smoking?		

Alcohol

Do you consume alcohol?	Yes	No
What type of alcohol do you consume?		
Rough estimate per week		

Do you believe your smoking habits should change?

Do you believe your alcohol habits should change?

Exercise

How active would you say you are daily?	Sedentary	Lightly active	Moderately active	Very active
What type of exercise do you do? (HIIT, yoga, running, etc)				
How would you rate your exercise?	None	Low	Moderate	Vigorous
How often do you exercise per week?	1 or 2 times	3 or 4 times	5 or 6 times	7+ times

How do you feel after exercise?

Have you sustained any sport injuries that have affected you long after the injury? Please elaborate

Sleep

How would you rate the quality of your sleep? Elaborate

Number of hours sleep per night

Number of times wake up during night

Indicate which of the following sleeping problems you experience

	Struggle to fall asleep		Need a sleeping tablet		Wake up in early hours
	Snore		Sleep apnea		Night terrors
	Insomnia		Restless legs		Sleep walking

13. Body Systems

Indicate which of the following signs and symptoms you are currently experiencing.

Mood

	Happy
	Anxious
	Obsessive
	Aggressive
	Irritable
	Depressed

Energy

	Permanent fatigue
	Fluctuates
	Afternoon dips
	Morning tiredness
	Dips after exercise
	Plenty

Psychology

	Depression
	Bipolar
	Anxiety
	Schizophrenia
	Previous self-harm
	Addiction history

Lungs

	Cough
	Shortness of breath
	Asthma
	Emphysema
	Blue fingers
	Smoker

Immune System

	Frequently ill
	Often on antibiotics
	Slow to recover
	Antihistamines
	Cortisone
	Chemotherapy

Joints and Muscles

	Aches and pains
	Cramping
	Stiffness
	Weakness
	Joint pain
	Back pain

Skin

	Dry
	Oily
	Scaly
	Eczema/Psoriasis
	Allergy/Rashes
	Acne/Abscesses

Nerves

	Weakness
	Pins and needles
	Burning feet
	Shooting pains
	Ataxia
	Tremor

Bladder

	Incontinence
	Leak if sneeze
	Frequent infection
	Wake up at night
	Urgency
	Weak stream

MEDICAL HISTORY FIRST VISIT FORM

Abdominal

	Cramping
	Diarrhoea
	Constipation
	Heartburn
	Ulcers
	Bloating
	Hiatus Hermina
	Previous colonoscopy
	When?
	Previous gastroscopy
	When?
	Feel full quickly
	Burping
	IBS

Heart

	Chest pain
	Palpitations
	Angina
	Irregular heart rate
	Shortness of breath
	Fluid retention
	Heart failure
	Low blood pressure
	High blood pressure
	High cholesterol
	Previous angiogram
	When?
	Previous cardiac surgery
	When?

Hormones

	Hot flushes
	Always cold
	Sweat excessively
	Sweat too little
	Morning tiredness
	Fatigue
	Poor sleep
	Swelling in neck
	Cold hands
	Cold feet
	Poor circulation
	Afternoon energy dips
	Crave salt
	Crave sugar

Eyes/Ears/Nose/Throat

	Spectacles
	Contact lenses
	Glaucoma
	Dry eyes
	Sinusitis
	Post nasal drip
	Lump in throat
	Thyroid
	Polyps
	Deafness
	Vertigo
	Allergies
	Difficulty swallowing
	Tonsils

Gynaecology

Last visit to gynae	
Last pap smear	
Last mammogram	
Last sonar	
Cancer	
Estrogen senstitivity	

Male Physical Exam

Last testicular exam	
Last prostate exam	
Last cholesterol test	
Last colon cancer screening	
Hair loss	

14. Gender Specific

Male Patients Only

Indicate which signs and symptoms you are currently experiencing.

	Reduced erectile function		Reduced sex drive		Loss of body hair
	Reduced erectile sensation		Loss of muscle mass		Loss of hair
	Loss of focus		Weak urine flow		Depression

How long have you been experiencing the above symptoms? Elaborate

Female Patients Only

Pregnancies

Ectopic		Breastfed babies	
Miscarriage		Difficulty falling pregnant	
Normal deliveries		Fertility treatment	
C-sections		Complications during pregnancy	
No. of living kids		Weight gain that couldn't be lost	
Children's ages		Post-partum depression	

Contraception

Current

Sterilised Yes No

When

How did you respond to contraception?

Used for

	Contraception
	Skin
	Period control

How long did you use contraception for?

Menstrual History

No of days bleeding	
Average length of cycle	
Last normal period	

How were/are your periods WITHOUT contraceptive?

	Regular		Light
	Irregular		Short
	Heavy		Long

Menstrual Symptoms

Rate your symptoms below from 1 to 10, where 1 is mild and 10 is severe

Headaches		Breast tenderness		Moody	
Bloated		Swelling		Irritable	
Fluid retention		Sugar craving		Emotional	

Hormone Therapy

Hormone Replacement Therapy (HRT) Yes No

If yes, please specify HRT history:

	Poly Cystic Oviarian Syndrome (PCOS)	Reason for hysterectomy
	Endometriosis	
	Hysterectomy	
	Age at hysterectomy	

General Symptoms

Rate your symptoms below from 1 to 10, where 1 is mild and 10 is severe

Hot flushes		Tiredness		Poor sleep	
Vaginal dryness		Thinning hair		Moody	
Unclear thinking		Vaginal thrush		Cellulite	
Fluid retention		Bladder leaking		Sweating	
Low libido		Weight gain on tummy		Facial hair	
Poor memory					

15. Additional Information

Is there anything else you wish for Dr Ledivia to know about/to address?

Patient Name and Surname

Thank you for taking the time to complete this form.

We understand that it is very time consuming, however these details are the difference between a normal consultation and a successful one.
At RevitaHealth, patient confidentiality is extremely important to us.

You can rest assured that your medical history and all information concerning yourself will be treated with the utmost respect and kept strictly confidential as regulated by the National Health Act 61 of 2003.

We look forward to walking your wellness journey with you!