DR GERHARD PIENAAR
ORTHOPAEDIC SURGEON

DR GERHARD PIENAAR INC
Orthopaedic Surgeon
MBChB, MMed(ORTHO), FC ORTH(SA)

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Form A: Medical information update

Date:________________

Name: ____

Surname: ____

Date of birth: ____

Age: ____________ years ____________months
Height: ______m ______cm
Weight: ______

Family physician: ____
Referring clinician: ____

Other therapist involved in your care:
____
____
____
____

Past medical history (conditions diagnosed and treated by a doctor):

- ☐ **None apply**
- ☐ Heart attack / Angina
- ☐ Heart failure
- ☐ Abnormal heart rhythm
- ☐ High blood pressure
- ☐ Stroke
- ☐ High cholesterol
- ☐ Poor blood circulation
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Bleeding disorder
- ☐ Blood clots in leg
- ☐ Blood clots in lung
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Anaemia
- ☐ ADHD
- ☐ Seizures
- ☐ Depression
- ☐ Migraine
- ☐ Cerebral palsy
- ☐ Spina bifida
- ☐ Thyroid problem
- ☐ Osteoporosis
- ☐ Stomach ulcer
- ☐ Gastric reflux
- ☐ Diabetes
- ☐ Osteo-arthritis
- ☐ Hepatitis (A/B or C)
- ☐ Cirrhosis (Liver)
- ☐ Hiatal hernia
- ☐ HIV / AIDS
- ☐ Neurofibromatosis
- ☐ Neuropathy
- ☐ Down's syndrome
- ☐ Cancer

If Yes: Type of cancer (if applicable)
____
____
____
____

- ☐ Other medical condition not mentioned above

Details:
____
____
____
____
____
____
____

Previous surgical episodes (all):

☐ No previous surgery

Operation	Date	Surgeon / Hospital

Previous problems with anaesthesia during surgery?

☐ YES
☐ NO

Details if YES:

Medication (prescription / over-the-counter):

☐ I do not take medication on a regular basis

Medication	Dosage	Reason

Allergies:

☐ I have no known allergies

Cause	Reason

Please list relevant family history of medical conditions:
(Immediate family – Mother / Father or siblings)

Work status:

Working ☐ Homemaker ☐ Unemployed ☐
Disabled ☐ Retired ☐ Student ☐

Occupation:____
____

Marital status:
Single ☐ Married ☐ Divorced ☐ Widowed ☐

Children
YES☐ NO☐
How many:____

Do you live alone?
YES☐ NO☐

If "NO", who lives with you?
____
____
____

Do you smoke?
YES☐ NO☐ Quit smoking☐

Do you use alcohol products?
YES☐ NO☐

Information provided by: ____