DR GrantFourie
GENERAL PRACTITIONER | SPECIAL INTEREST IN
FUNCTIONAL MEDICINE

The Village Square
Unit 107
Cnr Oxford & Queen Street
Durbanville | 7550
t: 021 919 3666
m: 084 558 2642
a/h: 021 949 2610
reception@drgrantfourie.co.za
doc@drgrantfourie.co.za
www.drgrantfourie.co.za

MEDICAL FILE NUMBER:

Medical History Form - *Please complete this form in as much detail as possible*

Patient Information

Date of consult: office use only

Name & Surname:			Title:	Relationship status:
ID:	Age:	Gender:		
Cell:		Email:		
Residential Address:				
Referred by:				

Why are you here? (Just the top 4 reasons)

	Duration		Duration
1.		3.	
2.		4.	

Main symptoms. Not diagnosis! Tell me what you feel and since when.

1.1	duration	1.5	duration
1.2	duration	1.6	duration
1.3	duration	1.7	duration
1.4	duration	1.8	duration

Existing medical conditions: What are you being treated for now?

2.1	duration	2.5	duration
2.2	duration	2.6	duration
2.3	duration	2.7	duration
2.4	duration	2.8	duration

Current medication: Please specify dosage and indicate how long you have used this

3.1	dosage/duration	3.6	dosage/duration
3.2	dosage/duration	3.7	dosage/duration
3.3	dosage/duration	3.8	dosage/duration
3.4	dosage/duration	3.9	dosage/duration
3.5	dosage/duration	3.10	dosage/duration

"Walking the path to better health, with you"

Previous surgery and age at time of surgery: (incl. cosmetic, orthopaedic, dental, childhood, minor or post-trauma)

4.1	age	4.4	age
4.2	age	4.5	age
4.3	age	4.6	age

Hospital admissions: Have you ever been admitted to hospital for any other reason? Please give details (includes Psychiatric or Rehab)

Infection History: Have you ever been treated for a tick bite or a spider bite or any other parasite infection? Details if yes. Y N

Supplements:

Do you use any supplements, homeopathic remedies, and/or natural products? Please specify.

Discontinued or changed supplements or medications due to negative reactions

Allergies:

Foods / medicines /animals / dust / grasses / jewellery / other

Dental history:

Number of metal fillings and/or crowns		Have you had any removed?	
Any braces or retainers still present?		Do you use a bite plate or grind your teeth?	
Other dental issues, please specify			

Previous Medical Conditions:

Have you ever been diagnosed or suspected of having any of the following? Please mark with an "X."

Anxiety		Arthritis		Asthma		Cancer		Cardiac disease	
Cholesterol		Chronic fatigue		Circulatory disorder		Depression		Diabetes	
Eczema		Epilepsy		Fibromyalgia		Gout		Hepatitis	
HIV		Hypertension		Kidney stones		Malaria		Migraine	
Renal disease		Spastic colon		Psoriasis		Thyroid		Tick bite fever	
Gallstones		Headaches		Hay fever		Porphyria		Diverticulitis	
Crohn's		Ulcerative colitis		Lung disease		COPD		Other	
If other, please specify:									

Family history: Please list any medical problems and/or cause of death of the following family members.

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

Work:

What do you currently do?			
Where have you worked in the past?			
How many hours do you work per week?		How many hours do you spend in traffic per week?	
Do you like what you do?			

Body composition: Please complete if known.

Current weight	kg	Best weight ever	kg	Desired weight	kg	Heaviest weight	kg
Height	m	Waist	cm	Hip	cm	Ratio Waist: Hip	
Weight gain or loss in last 5 years		Reason					

Smoker	Ex	Current	Never	How many per day?		How many years?		When last?	
Alcohol	Type and rough estimate of amount per week								
	Previously drank more	Y	N	Why the change?					
Exercise	Type?					Frequency?			
	How do you feel after exercise?								
Regular Hobbies	Include bee keeping / horse riding / Small home animals / hiking or other exposure to outdoor and nature areas								
Social	Married/Single	M/S	Kids at home		Co-habit		Remarried		Divorced/Widowed D/W
Diet	Do you follow a specific type of diet programme? eg. Banting, Paleo, Weight Watchers, Intermittent fasting								
Fluid	Daily intake of Water		What else do you drink?						
	Please indicate how many of these you consume per day								
	Coffee		Tea		Sugars		Energy drinks (eg. Red Bull)		Type of sweetener
Sleep	Quality					Number of hours			
	Average bedtime?		Average wake time?		Do you feel refreshed in the morning?				
	Do you experience any of the following? Please mark with an "X."								
	Struggle to fall asleep		Must use sleeping tablet		Wake in early hours, can't sleep		Snore		Stop breathing
Religion	Spiritual / Religious affiliations?								
Narcotic Use	Previous use of any drugs or hallucinogens?	Y	N	If yes, please mark with an "X"					
	Mushrooms	Ayahuasca	Ibogaine	LSD	MDMA	Dagga	Cocaine / Heroine / TIC		
	Previous rehab admission for addictions?								
Pets	What pets do you keep?								

Body systems: Do you experience any of the following? Please mark with an "X."

Mood:											
Happy		Anxious		Obsessive		Aggressive		Irritable		Depressed	
Energy:											
Permanent fatigue		Fluctuates		Afternoon dips		Morning tiredness		Dips a few hours after exercise		Plenty	
Abdominal:											
Cramping		Diarrhoea		Constipation		Heartburn		Ulcers		Hiatus hernia	
Gastroscopy		Colonoscopy		Previous surgery		Bloating		Feel full quickly		Burping	
Haemorrhoids		Spastic colon		IBS		SIBO		H. Pylori		Bleeding top or bottom	
Heart:											
Chest pain		Palpitations		Angina		Irregular heart rate		Previous angiogram		Heart murmur	
Heart failure		Fluid retention		Short of breath quickly		High blood pressure		Low blood pressure		Cholesterol meds	
Lungs:											
Short of breath		Cough		Asthma		Emphysema		Still smoking		Fingers go blue	
Joints and muscles:											
Aches and pains		Cramping		Stiffness		Weakness		Joint pain		Back pain	
Nerves:											
Weakness		Pins and needles		Burning feet		Shooting pains		Ataxia/ Off-balance		Tremor	
Bladder:											
Incontinence		Leak if sneeze		Frequent infection		Get up at night		Urgency if need to go		Weak stream	
Gynae:											
Last visit to gynae	20 ….	Last pap smear	20 ….	Last mammogram	20 ….	Last sonar	20 ….	Cancer		Oestrogen sensitive	
Immune system:											
Get sick easily		Slow to heal or recover		Frequent antibiotics		Antihistamines		Cortisone		Chemotherapy	
Hormones:											
Fatigue		Feel hot		Always cold		Sweat a lot		Sweat too little		Hot flushes	
Crave salt/sugar or chocolate		Afternoon Energy dips		Poor sleep		Swelling in neck		Cold hands or feet		Poor circulation	
Psychology:											
Depression		Bipolar		Anxiety		Schizophrenia		Previous self-harm		Addiction history	
Skin:											
Dry		Oily		Scaly		Dermatitis/ Psoriasis		Allergy/ Rashes		Abscesses/ Acne	
Eyes/Ears/Nose/Throat:											
Spectacles		Contacts		Glaucoma		Dryness of eyes		Sinusitis/ Postnasal drip		Dizziness	
Allergies		Vertigo		Polyps		Deafness		Lump in throat		Thyroid	
Other:											

MALE PATIENTS ONLY

Do you experience any of the following? Please mark with an "X."					
Problems with erection or sensation		Problems with ejaculation		Low libido	
How long have these been a problem?					

Do you experience any of the following? Please mark with an "X."							
Tendency to procrastinate		Increase in anxiety levels		Grumpy		Anti-social	
Snoring/Sleep apnoea		Fall asleep in front of TV		Fatigue		Urinate more at night	
Must run if bladder full		Urine pressure low / Have to wait for flow					

FEMALE PATIENTS ONLY

General symptoms: Rate from 1 to 10 where 1 is "Okay" and 10 is "Really bad."

Hot flushes		Tiredness		Poor sleep		Low libido	
Skin dry		Vaginal dryness		Hair loss/thinning		Moody	
Poor memory		Unclear thinking		Vaginal thrush		Cellulite	
Weight gain on tummy		Swelling/fluid retention		Bladder leaking		Sweating	
Hair growth on face							

Pregnancies	Ectopic		Miscarriage		No. of living children		Children's ages
	Normal deliveries		Caesareans		Fertility treatment		
	Difficulty falling pregnant	Y/N	Medical conditions during/after pregnancy				
	Weight gain that couldn't be lost		Breastfed babies	Y/N			
	Depression after pregnancy						
Contraceptives	Current		Previous		Sterilised	Y/N	
	How did you respond to contraceptives?						
	Used for:	Contraception		Skin / Acne		Period control		Total years on contraceptive?
Period History	Average length of cycle		No. of bleeding days		Last normal period		
	How are/were your periods without a contraceptive? Please mark with an "X.						
Period Symptoms	Regular	Irregular	Heavy	Light	Short	Long	Painful
	Please rate symptoms before/during your period from 1 to 10 where 1 is "Mild" and 10 is "Severe."						
	Headaches		Breast tenderness		Moody		Bloated
	Swelling		Irritable		Fluid retention		Sugar cravings
Hormone therapy	Hormone Replacement Therapy (HRT)	Y/N	If "yes," please specify HRT history				
Medical	Poly Cystic Ovarian Syndrome (PCOS)	N/A					
	Endometriosis	N/A					
Hysterectomy	N/A		Age at hysterectomy				
	Reason for hysterectomy:						