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Patient information form

Submit this form via: ***Email: admin@clinresco.co.za*** or ***Fax: 011 394 6440***

Name: _____

Date of birth: _____ Gender: _____

Contact number: _____ E-mail address: _____

Do you have any chronic conditions for which you take regular medication? _____

If yes, please indicate which condition(s) have been diagnosed:

Osteoarthritis	Yes	No	*Which joints?*
Rheumatoid arthritis	Yes	No	
Psoriatic arthritis	Yes	No	
Myocardial infarction (heart attack)	Yes	No	
Hypertension	Yes	No	
Crohn's disease	Yes	No	
Ulcerative colitis	Yes	No	
Diabetes mellitus	Yes	No	*Type I or II?*
High cholesterol	Yes	No	
Skin diseases	Yes	No	*Specify:*
COPD	Yes	No	
Other	Yes	No	*Specify:*

What medications are you currently taking?

_____

_____

_____

_____

_____

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