WELLNESS APPOINTMENT QUESTIONNAIRE

Please use black pen to complete

Full name and surname as per ID Document	
	Preferred Calling Name
ID Number	Age
Gender	Occupation
Medical Aid	Cellphone Number
Email address	How did you hear about us?
Suburb	City / Town
Province	
Height	Weight
Regular Family Doctor	
Your daily diet preference ie. Vegetarian / Pescatarian / Vegan / Regular all food diet etc. ?	

MEDICAL HISTORY / CURRENT MEDICAL CONDITIONS & MEDICATION

Are you allergic to any medication? (If yes, please state which medication)
Do you have, or ever have been diagnosed with an irregular heartbeat / arrythmia? If answer is 'yes' please elaborate in detail below:

Do you have any medical conditions or on treatment for anything? If yes, state which:
Have you ever been admitted to Hospital / Clinic for illness or condition? If yes, please state incident and when:

ARE YOU CURRENTLY TAKING MEDICATION INCLUDING SUPPLEMENTS/OVER THE COUNTER MEDICATION (IF YES, PLEASE LIST THE MEDICATION BELOW) PLEASE BRING MEDICATION WITH YOU TO YOUR FIRST APPOINTMENT.

Name of Medication	Dosage
1.	
2.	
3.	
4.	
5.	
6.	

PLEASE LIST ANY OPERATIONS / MEDICAL PROCEDURES YOU HAVE HAD:

1	7
2	8
3	9
4	10
5	11
6	12

DO YOU HAVE/OR PREVIOUSLY HAD ANY ADDICTIONS OR REHABILITATION?

DO YOU HAVE/OR PREVIOUSLY HAD ANY EATING DISORDERS?

FEMALE PATIENTS

Are you pregnant/trying to fall pregnant or currently breastfeeding?	

IF YOU AR EPREGNANT, TRYING TO FALL PREGNANT, NOT SURE IF YOU ARE PREGNANT OR IF YOU ARE BREAST FEEDING – YOU CANNOT EMBARK ON THE PROGRAM. IF YOU FALL PREGNANT WHILST ON THIS TREATMENT, YOU CANNOT REMAIN ON THE PROGRAM.

HISTORY OF PREVIOUS PREGNANCIES

Vaginal Deliveries	C Sections
Miscarriages	Are you currently taking any form of Contraception – If yes – please advise

Please state if you have had tubal ligation or if your spouse has had a Vasectomy?

ALL PATIENTS

Are you currently undergoing fertility treatment ?

Have you undergone fertility treatment in the past ?

YOUR HISTORY OF MEDICAL CONDITIONS AND THAT OF YOUR DIRECT FAMILY (BLOOD RELATIVES ONLY– PLEASE SPECIFY WHICH FAMILY MEMBERS – Mom/Gran/Uncle)

Do you have Glaucoma?

Do you or any of your family have high cholesterol?

Do you or any of your family members have high blood pressure?

Do you or any of your family members have sugar diabetes?

Do you or any of your family have a heart condition? (i.e., Heart attack / Bypass procedures / Stents / Angina – please elaborate for this condition)

Do you or any of your family have an under active thyroid?

Do you or any of your family have Asthma?

Do you or any of your family have Epilepsy?

Do you or any of your family have mood disorders or anxiety disorder?

Have you or any of your family been treated for Cancer?

Have you or any of your family had deep vein blood clots?

Have you or any of your family experienced a Stroke?

Do you or your family have any Chronic Conditions not listed on this page?

Do you Smoke ?	If yes, how many?
Do you exercise ?	If yes, what kind and how often?
Do you consume alcohol?	If yes, how often

Terms and Conditions of being treated at our Practice

- Please confirm and honour appointment dates and times.
- Cancellations may be communicated via email to requests@buchananwellness.co.za or liz@buchananwellness.co.za. Please notify us at least a day ahead or before 09h00 on the day of your appointment.
- Please be punctual for your appointment.

- If you arrive more than 15 minutes after your scheduled appointment time, the Doctor may require you, depending on the constraints, to reschedule your appointment for another day.
- Do take particular care of prescriptions you are issued with. Some scripted items are scheduled medication and may under no circumstances be re-scripted due to expiry, loss, damage or theft of prescriptions.
- Prescriptions that are altered or tampered with by a patient will not be re-issued and patients may face consequences.
- Should an appointment need to be rescheduled by the Practice or the Doctor due to unforeseen circumstances, neither the Practice, nor the Doctor will be held accountable for any cost incurred in any travel arrangements.
- All effort will be made to notify patients well ahead of time should this occur.
- It is important to disclose all medical information in its entirety. If a patient does not disclose all medical information, the Doctor has the right to terminate the relationship.
- Dr Galvin and Dr Lochner share premises and practice independently of each other. Should there be any ensuing liability this would lie with the treating Doctor.
- Please note any recording of consultations is strictly prohibited.
- Right of Admission is Reserved

POPIA

Kindly assist us in our effort to enact all conditions of Section 58(2) of POPIA from 1 February 2022 by accepting this notification from Dr Galvin Inc at Buchanan Wellness at A6 Meyrickton Park, 2 Meyrickton Place, Hillcrest 3610.

As a Medical General Practice we hereby request to obtain your prior authorisation to process a specific category of personal information from you as a patient for the sole purpose of processing medical reports, test results, treatment history and treatment planning to specified referred Medical Colleagues, Specialists and Medical Schemes within the reference frame of your treatment and upkeep of general wellbeing. The Practice makes use of electronic communication for sending statements and patient centred data. You hereby consent to having private information communicated via email, text messaging or whatsapp, within the reference relevant to your general health and treatment and that of your family under the age of consent.

As the patient it is your responsibility to ensure that the relevant personal information records remain up to date.

Please date and sign this document to acknowledge that you have read, understand and accept all the terms and conditions in this document.

Signature	Date