Dr Deon Weyers
PLASTIC AND RECONSTRUCTIVE SURGEON

CLIENT'S PERSONAL DETAILS					
SURNAME					
NAME					
MOBILE NUMBER					
EMAIL					
HOME ADDRESS					
CITY				CODE	
COUNTRY					
POSTAL ADDRESS					
ID NUMBER		DOB		AGE	
OCCUPATION		RELIGION			
HEIGHT		WEIGHT			
NEXT OF KIN NAME		NEXT OF KIN NR			

ADDITIONAL CLIENT INFORMATION			
WORK TEL		FAX NUMBER	
GENDER		ETHNICITY	
HOME LANGUAGE		MARITAL STATUS	
HOW DID YOU HEAR ABOUT US			
REFFERRING PHYSICIAN AND CONTACT NR:			
I AM INTERESTED IN THE FOLLOWING PROCEDURES:			

Yes! Sign me up to the Dr Deon Weyers VIP Patient Communicator Program. Please email and text info to my phone about:

Promotional Offers	☐	Discounts	☐
Special events & Workshops	☐	Appointment Reminders	☐
New Product & Service details	☐	SMS Vouchers & Coupons	☐

MEDICAL HISTORY				
Do you have a bleeding disorder or do you ever suffer form excessive bleeding?	NO	YES	DETAILS	
Have you ever had high blood pressure?	NO	YES	DETAILS	
Have you ever had a blood transfusion?	NO	YES	DETAILS	
Have you ever had a stroke, heart attack or angina?	NO	YES	DETAILS	
Have you ever had a heart murmur?	NO	YES	DETAILS	
Have you ever had an ECG?	NO	YES	DETAILS	
Do you suffer from Asthma or ever had any breathing problems?	NO	YES	DETAILS	
Do you suffer form Lupus?	NO	YES	DETAILS	
Have you ever been diagnosed with Cancer?	NO	YES	DETAILS	
Do you suffer from Fibromyalgia?	NO	YES	DETAILS	
Do you suffer from Arthritis	NO	YES	DETAILS	
Do you suffer from Scleroderma?	NO	YES	DETAILS	
Do you have AIDS/ HIV/ Tuberculosis?	NO	YES	DETAILS	
Do you have any Thyroid related problems?	NO	YES	DETAILS	
Do you have any kidney related problems?	NO	YES	DETAILS	
Do you have any Gallbladder related problems?	NO	YES	DETAILS	
Do you have any Stomach problems e.g.. previous or current ulcer?	NO	YES	DETAILS	
Have you ever suffered from bowel or urinary problems?	NO	YES	DETAILS	
Do you suffer from any abnormalities of the Nervous System eg epilepsy?	NO	YES	DETAILS	
Have you ever used any anti-depressant/ anxiety treatment/ mental health medication?	NO	YES	DETAILS	
Have you ever seen a psychiatrist or psychiatric councillor?	NO	YES	DETAILS	
Have you ever suffered from Jaundice or Hepatitis A, B or C?	NO	YES	DETAILS	
Have you suffered from neck, back, muscle or joint problems?	NO	YES	DETAILS	
Do you suffer from Diabetes?	NO	YES	DETAILS	
Have you ever had any problems with wound healing such as keloid scarring?	NO	YES	DETAILS	
Do you suffer from any other serious illness?	NO	YES	DETAILS	
Do you smoke?	NO	YES	*How many a day?* *If you recently stopped, when last did you smoke?*	
Do you drink more than 3 cups of coffee or green tea per day?			NO	YES
Do you drink alcohol?	NO	YES	*What do you drink?* *How much do you drink?*	

MEDICATION HISTORY AND ALLERGIES

Are you presently taking any of the following?

Aspirin	NO	YES	Iron	NO	YES
Cough Medicine	NO	YES	Motrin	NO	YES
Antibiotics	NO	YES	Hormones	NO	YES
Phenobarbital	NO	YES	Insulin/Diabetes medication	NO	YES
Dilantin	NO	YES	Anti-inflammatories	NO	YES
Bloodthinners eg:			Birth Control Pills	NO	YES
Warfarin or Heparin	NO	YES	Arthritis medication	NO	YES
Aspirin	NO	YES	Sleeping Pills	NO	YES
Vitamin E	NO	YES	Cortisone/ Steroids	NO	YES
Blood Pressure Pills	NO	YES	Water Pills	NO	YES
Thyroid medication	NO	YES	Bufferin	NO	YES

Do you take ANY other medication? **Incl Vitamin/ Mineral, Herbal or Dietery Supplements**

Do you have any allergies? **Incluing Latex, Plasters, Cleaning agents and Medications**

OPERATION HISTORY

Have you ever had local/ general anaesthetic/ sedation? If YES, please list full details			NO	YES
Procedure	Year	Full Details		
Procedure	Year	Full Details		
Procedure	Year	Full Details		
Have you ever had an adverse reaction to a local/ general anaesthetic/ sedation?			NO	YES
Did you ever have any post-operative complications?			NO	YES

ONLY WOMEN NEED TO ANSWER THIS SECTION

Is there any chance you might be pregnant?	NO	YES	Full Details
Regular menstruations? Date of last period?	NO	YES	Full Details
How many pregnancies have you had? (including miscarriages and tubal pregnancies)			Full Details
Did you ever breastfeed?	NO	YES	Full Details
Have you ever had a Mammogram. If YES, when was it done?	NO	YES	Full Details
Have you ever had a breast biopsy?	NO	YES	Full Details
Have you ever been diagnosed with Breast Cancer?	NO	YES	Full Details

FAMILY HISTORY

Have any of your blood relatives had?			
Arthritis	*NO*	*YES*	*Full Details*
Diabetes	*NO*	*YES*	*Full Details*
Bleeding Disorder	*NO*	*YES*	*Full Details*
Cancer	*NO*	*YES*	*Full Details*

Are you planning a holiday in the near future?	*NO*	*YES*	*When*	*Where*

DISCLAIMER

I confirm that the above health history is accurate and complete. I understand that withholding any medical information will be detrimental to my health and safety during the procedure that the surgeon agrees to undertake.

I consent to the disclosure of sensitive personal data to relevant doctors, surgeons, nurses and other health professionals for the purpose of discussing any surgical or medical procedure concerning myself.

Signed……. Date……

CONSULTATION NOTES