FOR FIRST TIME PATIENTS

Please provide the following medical information. Please specify with a tick if you have any of the following conditions:

Diabetes (High Blood Sugar)	
Hypertension (High Blood Pressure)	
Angina (Heart Disease)	
Hyperlipidaemia (High Cholesterol)	
Asthma	
Epilepsy	
Hyperthyroidism (Over active Thyroid)	
Hypothyroidism (Under active Thyroid)	
Polycystic Ovarian Syndrome / Endometriosis	
Emphysema (COPD)	
Any other not mentioned above?	

Are you on any other chronic medication and if so, please provide the name and dosage below:

_____

_____

_____

Do you have any allergies and/or medication allergies?

_____

Please specify if you have had any operations or surgeries in the past (include the date or rough estimate as to when)

_____

_____

_____

Are you a smoker? If yes, please specify how many cigarettes per day

_____

Do you take in alcohol?

No	Very rarely	Occasionally	Heavy drinker

Please specify if you have a history of chronic conditions or cancer in your family

_____

_____

_____

Please provide the name and speciality (and contact details if possible) of referring Doctors and previous Doctors

_____

_____

_____

What is the reason for seeing Dr Ashnee Govender?

_____

_____

_____

How did you hear about us?

_____

_____

THANK YOU ☺

DR. ASHNEE GOVENDER INC.
SPECIALIST PHYSICIAN

Please forward all forms to the receptionist at drgovender.rmc@gmail.com

For any further queries pertaining to this form call 021 685 0547