GENERAL HISTORY – COMPLETED BY (OR FOR) THE APPLICANT

Please complete the following details	This information is essential for us to understand your personal circumstances and your overall health. Our assessment and final recommendations will try to balance the various findings and provide accurate and effective guidance for optimizing your health or your care.

Field		Field	
Surname			
First Names		D.O.B:	Y Y Y Y M M D D
Employee No.		Medical Scheme	
Medical Scheme Number		Occupation:	
Employer No.		Department:	
Address:		Division:	
		Email:	
Postal code	Area Code	Home No.:	
Home No.:		Fax No.:	
Marital Status:	Single / Married / Divorced	Gender:	Male / Female

Number Dependants	Number of children	Children's ages	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6

Body statistics	This section will provide information about your general physical shape. We compare your statistics to actuarial tables and matched populations of similar age and sex.

Has your weight changed in the last 3 months?	Y	N	Weight lost (kg)	Weight gained (kg)
Weight: (kg)	Height: (M) . M		Waist (cm)	

EXERCISE	**Please tell us about how physically active you are in your life?** We want to understand how much exercise you get, its impacts on your lifestyle and whether this is sufficient for your needs.

Question	Options				
Do you exercise?	Yes	No			
If yes, how many times per week do you exercise?	More than 5	Less than 3	3-5	Occasionally	Never
How long is each session?	Less than 15 minutes	15 – 30 minutes	More than 30 minutes		
While you exercise, do you perspire?	Not at all	Lightly and slightly breathless			
	Lightly but no change in breathing	Heavy and very breathless			
How long does it take to recover after exercising?	Within an hour	Within a day			
	More than a day	Cannot continue normal activities on day of exercising			

SMOKING	**This measures an important risk factor in overall health!** Please be honest about your smoking! We cant give you good advice if we don't understand the risk factors.

Do you smoke?	Yes		No		If yes, how long have you been smoking for?	Months		Years		

How many cigarettes smoke per day?	Less than a pack a day		1-2 packs a day		More than 2 packets a day		
If an ex-smoker, how many cigarettes did you smoke per day?	Less than a pack a day		1-2 packs a day		More than 2 packets a day		

How long ago did you stop smoking?	Less than 6 months		6-12 months		More than a year		More than 5 years		

If you are a non-smoker, do you share living space with a smoker?	If you do, what best describes the shared space?	Living room		Bedroom		Workplace	

ALLERGIES

Do you suffer from allergies?	None		Dust Pollen		Pets		Meds		Workplace allergies		Other	

GENERAL HISTORY – COMPLETED BY THE APPLICANT (or by care-giver)

Are you receiving or have you ever received medical treatment or advice for any of the conditions listed BELOW? If **"Yes" Please tick your answer *and*** state full details of each instance in the schedule for commentary below.		YES	NO
1	**Have you ever been advised not to do shift work, night work, or any kind of work?**		
2	**Have you ever had a serious occupational accident or an occupational disease? If so, indicate any compensation received.**		
3	**Do you regularly use medication of any sort? Please list these in the space provided below.**		
4	**(Those already employed) Do you think that your current workplace may be affecting your health? If so, please explain below. This is important to us.**		
5	**Disorder of the heart, eg. Rheumatic fever, heart murmur, shortness of breath, palpitations, chest pains, angina or heart attack?**		
6	**High blood pressure, high cholesterol or circulatory disorder, including a stroke, or cramps in the calves with exercise, etc.?**		
7	**Respiratory or lung trouble, eg. asthma, bronchitis, persistent cough, tuberculosis?**		
8	**Disorder of the digestive system, gall bladder, pancreas or liver, eg. recurrent heart burn, ulcer, or jaundice?**		
9	**Disease or disorder of kidneys, bladder or reproductive organs, eg protein or blood in the urine, kidney stones, infections.**		
10	**Nervous or mental complaint, eg fits, epilepsy, blackouts, weakness, numbness, anxiety state or depression, or fear of heights or fear of enclosed spaces?**		
11	**Eye, ear, nose or throat disorder, eg. impaired vision, hearing loss, ear discharge, hoarseness, required use of hearing aids**		
12	**Disorder or disease of muscles, bones, joints, limbs or spine, eg. rheumatism, arthritis, gout, slipped disc or other back trouble?**		
13	**Disorder or disease of skin, eg. dermatitis / eczema, psoriasis?**		
14	***Diabetes, sugar in urine, thyroid disease or other glandular disorder?***		
15	**Disorders of the blood? eg. bleeding disorders, deficiencies of the immune system, leukaemia, lymphoma?**		
16	**Cancer, growth or tumor of any kind?**		
17	**Any tropical disease, eg bilharzia or malaria?**		
18	**Any other illness, disorder, operation or hospitalisation?**		
19	**Have you ever had any X-rays, audiograms or other medical investigations? (Excepting for insurance or routine medical check-ups)**		
20	**Have you ever been denied Life Insurance or been requested to pay increased premiums?**		
21	**Do you have any of the following hobbies? Working on cars, keeping pigeons/birds, target shooting, diving, gardening, etc**		
22	**Have you ever been referred to a specialist for a medical evaluation, opinion or treatment?**		

#	Please provide further details regarding any question to which you answered yes to above	Name of treating doctor	Area code / Telephone	

Please tell us about your family's history. Please answer by checking (✓) which illnesses your family have experienced	Father	Mother	Brothers	Sisters	
How many siblings do you have (brothers and sisters)?	Please write in the number of brothers and sisters >>>>>>>>>>>				
Are family members still alive? (✓) = alive (✗) = deceased					
Current age, or alternatively age at which they were deceased?					
Cardiovascular disease. This includes heart attacks, strokes, aneurysms, high blood pressure,					
Raised Cholesterol					
Diabetes. Taking either tablets or injecting insulin.					
Respiratory disorders. This includes asthma, repetitive bronchitis					
Porphyria?					
Breast cancer					
Cancers of any kind other than breast cancer					
Psychological problems. This includes depression, anxiety and stress problems, personality disorders, schizophrenia					
Any other disorder that runs in your family or is inherited?					

Have you been admitted to hospital in the last 2 years?	**Yes**		If yes, please provide further details regarding admissions to hospital		
Nature of the problem requiring admission to Hospital.	**Related to your PILIR Application?**	**Approximate date of admission**	**Name of treating doctor**	**Area code / Telephone**	

Please complete the details of the ***main doctors*** who have looked after you or assessed your case – by providing this information, you authorize us to request confidential medical records, which will be maintained as patient/doctor privileged documents and will not e shared or forwarded further without your explicit consent.

General Practitioner

Name: Dr

Practice #:

Discipline:

Address:

Tel Code *Postal Code*

Work Tel

Fax

Cell

Email

Principal Specialist

Name: Dr.

Practice #:

Discipline:

Address:

Tel Code *Postal Code*

Work Tel

Fax

Cell

Email

Other Specialists

Name: Dr

Practice #:

Discipline:

Address:

Tel Code *Postal Code*

Work Tel

Fax

Cell

Name: Dr.

Practice #:

Discipline:

Address:

Tel Code *Postal Code*

Work Tel

Fax

Cell

TREATMENT YOU HAVE RECEIVED ASSESSMENT OF CURRENT THERAPIES							IF IN YOUR OPINION, ANY OF THE THERAPIES ARE INEFFECTIVE, INAPPROPRIATE OR HAVE SIGNIFICANT SIDE EFFECTS, PLEASE SEE **TREATMENT RECOMMENDATIONS** BELOW		
TYPE OF THERAPY	**SESSIONS / TREATMENTS**	**COURSE DURATION**	**COMPLIANCE TO TX**	**MOTIVATION LEVELS**	**COOPERATION TO TX**		**EFFECTIVE ?**	**APPROPRIATE ?**	**ILL EFFECTS?**
	# per dy / wk / mo	# dy / wk / mo/ yr	1 = poor, 10 = excellent	1 = poor, 10 = excellent	1 = poor, 10 = excellent		1 = poor, 10 = excellent	1 = poor, 10 = excellent	1 = Nil, 10 = significant
EXAMPLE OF HOW TO COMPLETE THE TABLE									
# **PHYSIOTHERAPY**	3 X WK	3 MO	5	5	5		8	10	2
1 CARE OF A GENERAL PRACTITIONER									
2 PHARMACOTHERAPY IN GENERAL	Dealt with in other assessments								
3 PHYSIOTHERAPY									
4 OCCUPATIONAL THERAPY									
5 PSYCHOLOGICAL COUNSELING									
6 CARE OF A PSYCHIATRIST									
7 CARE OF A CARDIOLOGIST									
8 CARE OF A RESPIRATORY PHYSICIAN									
9 CARE OF A RHEUMATOLOGIST									
10 CARE OF AN ORTHOPOD									
11 VOCATIONAL REHABILITATION									
12 GENERAL CONDITION EDUCATION / COUNSELING									
13									
14									
15									
16									

YOUR ASSESSMENT OF TREATMENT	NIL		POOR		MODERATE		GOOD		EXCELLENT	
PLEASE RATE THE FOLLOWING CATEGORIES OF TREATMENT 1 = NO RESPONSE, 10 = EXCELLENT	1	2	3	4	5	6	7	8	9	10
An example of how to complete this question										
# eg. My response to my GP's treatment									✓	
1. Response to GP's treatment?										
2. Response to Medical Therapy: e.g., Pill, injections, etc.										
3. Response to Surgical Therapy: e.g., Operations / Procedures										
4. Response to Physical Therapy / Physiotherapy / Biokinetics										
5. Response to Occupational therapy										
6. Response to Psychological: Psychologist, Counselor, Psychiatrist										
7. Response to Alternate healers therapies										

If you have had any other therapies that you wish to comment on please do so below										
8.										
9.										
10.										
11.										
12.										

If there is anything else you feel that is important please note each separate matter in a new box below

TREATMENT : MEDICATION

PLEASE WOULD YOU COMPLETE THE FOLLOWING TABLE TO RECORD THE CURRENT MEDICATION REGIMEN.

IF IN YOUR OPINION ANY OF THE MEDIATION IS INEFFECTIVE, INAPPROPRIATE OR GIVING SIGNIFICANT SIDE EFFECTS, PLEASE SEE **TREATMENT RECOMMENDATIONS** BELOW

	DRUGS TRADE NAME DRUGS SCIENTIFIC NAME	DOSE	UNITS OF DOSE	FREQUENCY	ROUTE	COURSE DURATION	DURATION ON THIS DRUG	EFFECTIVE?	APPROPRIATE?	SIDE EFFECTS?
		numeric	units	? X per time	PO / PR/TD/injj	Dy / wk / mo	? per Dy / wk / mo/	1 = poor, 10 = excellent	1 = poor, 10 = excellent	1 = Nil, 10 = significant

EXAMPLE OF HOW TO COMPLETE THE TABLE

	DRUGS TRADE NAME DRUGS SCIENTIFIC NAME	DOSE	UNITS OF DOSE	FREQUENCY	ROUTE	COURSE DURATION	DURATION ON THIS DRUG	EFFECTIVE?	APPROPRIATE?	SIDE EFFECTS?
	PHARMAPRESS LISINOPRIL	10	MG	1 X DAY	PO	1/12 X 12	3 YRS	8	10	2
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Summary of Investigations that have been undertaken in the evaluation of this case.		Diagnosis being investigated	Investigator			
Nature of investigation	Description of the diagnosis / details regarding investigations	ICD10	GP	SP1	SP2	SP3
CXR						
Ultrasound						
CT Scan						
MRI Scan						
Other						
INVASIVE						
1. Endoscopy						
2. Angiogram						
Other						
Other						
Other						
LABORATORY						
Hematology						
Other						
Other						
Other						
Other						
Other						
Other						
Other						

Continued ▸

Additional medical or other information not covered above - that would have bearing on your health in any way.

PATIENT SELF SCORING PAIN IMPACT : Rand SF_36 Health Short Form Survey

THIS IS A STANDARDIZED TEST DEVELOPED BY AS PART OF THE MEDICAL OUTCOMES STUDY (MOS) — A MULTI-YEAR, MULTI-SITE STUDY TO EXPLAIN VARIATIONS IN PATIENT OUTCOMES. RAND CORP. A USA BASED RESEARCH NGO DEVELOPED THE 36-ITEM SHORT FORM HEALTH SURVEY (SF-36). SF-36 IS A SET OF GENERIC, EASILY ADMINISTERED QUALITY-OF-LIFE MEASURES. THESE MEASURES RELY UPON PATIENT SELF-REPORTING AND ARE IS WIDELY UTILIZED BY MANAGED CARE ORGANIZATIONS AND BY THE MEDICARE PROGRAM FOR ROUTINE MONITORING AND ASSESSMENT OF CARE OUTCOMES IN ADULT PATIENTS.

	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
1. IN GENERAL, WOULD YOU SAY YOUR HEALTH IS					
	MUCH WORSE	WORSE	SAME	BETTER	MUCH BETTER
2. COMPARED TO ONE YEAR AGO, HOW WOULD YOU RATE YOUR HEALTH IN GENERAL NOW?					
IN A TYPICAL DAY, HOW WOULD YOU RATE YOUR ABILITY TO PERFORM THESE NORMAL ACTIVITIES	NOT LIMITED	LITTLE LIMITED	LIMITED	VERY LIMITED	SEVERE LIMITED
3. VIGOROUS ACTIVITIES, SUCH AS RUNNING, LIFTING HEAVY OBJECTS, PARTICIPATING IN STRENUOUS SPORTS					
4. MODERATE ACTIVITIES, SUCH AS MOVING A TABLE, PUSHING A VACUUM CLEANER					
5. LIFTING OR CARRYING GROCERIES					
6. CLIMBING SEVERAL FLIGHTS OF STAIRS					
7. CLIMBING ONE FLIGHT OF STAIRS					
8. BENDING, KNEELING, OR STOOPING					
9. WALKING MORE THAN A MILE					
10. WALKING SEVERAL BLOCKS					
11. WALKING ONE BLOCK					
12. BATHING OR DRESSING YOURSELF					
DURING THE PAST 4 WEEKS, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR WORK OR OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR PHYSICAL HEALTH	NO	YES			
13. CUT DOWN THE AMOUNT OF TIME YOU SPENT ON WORK OR OTHER ACTIVITIES					
14. ACCOMPLISHED LESS THAN YOU WOULD LIKE					
15. WERE LIMITED IN THE KIND OF WORK OR OTHER ACTIVITIES					
16. HAD DIFFICULTY PERFORMING THE WORK OR OTHER ACTIVITIES (FOR EXAMPLE, IT TOOK EXTRA EFFORT)					
DURING THE PAST 4 WEEKS, TO WHAT EXTENT HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS INTERFERED WITH YOUR NORMAL SOCIAL ACTIVITIES WITH FAMILY, FRIENDS, NEIGHBORS, OR GROUPS	YES	NO			
17. CUT DOWN THE AMOUNT OF TIME YOU SPENT ON WORK OR OTHER ACTIVITIES					
18. ACCOMPLISHED LESS THAN YOU WOULD LIKE					
19. DIDN'T DO WORK OR OTHER ACTIVITIES AS CAREFULLY AS USUAL					
20. DURING THE PAST 4 WEEKS, TO WHAT EXTENT HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS INTERFERED WITH YOUR NORMAL SOCIAL ACTIVITIES WITH FAMILY, FRIENDS, NEIGHBORS, OR GROUPS					
	NONE	VERY MILD	MILD	SEVERE	EXTREME
21. HOW MUCH BODILY PAIN HAVE YOU HAD DURING THE PAST 4 WEEKS					
22. DURING THE PAST 4 WEEKS, HOW MUCH DID PAIN INTERFERE WITH YOUR NORMAL WORK (INCLUDING BOTH WORK OUTSIDE THE HOME AND HOUSEWORK)?					

Rand SF_36 Health Short Form Survey

QUESTIONS 20 - 36

	NONE	SLIGHTLY	MODERATE	QUITE A BIT	EXTREMELY
THESE QUESTIONS ARE ABOUT HOW YOU FEEL AND HOW THINGS HAVE BEEN WITH YOU DURING THE PAST 4 WEEKS. FOR EACH QUESTION, PLEASE GIVE THE ONE ANSWER THAT COMES CLOSEST TO THE WAY YOU HAVE BEEN FEELING.	NONE OF THE TIME	A LITTLE OF THE TIME	HALF OF THE TIME	MOST OF THE TIME	ALL OF THE TIME
23. DO YOU FEEL FULL OF ENERGY OR VIGOR?					
24. HAVE YOU BEEN A VERY NERVOUS PERSON?					
25. HAVE YOU FELT SO DOWN IN THE DUMPS THAT NOTHING COULD CHEER YOU UP?					
26. HAVE YOU FELT CALM AND PEACEFUL?					
27. DID YOU HAVE A LOT OF ENERGY?					
28. HAVE YOU FELT DOWNHEARTED AND BLUE?					
29. DID YOU FEEL WORN OUT?					
30. HAVE YOU BEEN A HAPPY PERSON?					
31. DID YOU FEEL TIRED?					
32. HOW MUCH OF THE TIME HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS INTERFERED WITH YOUR SOCIAL ACTIVITIES (LIKE VISITING FRIENDS, RELATIVES, ETC.)?					
HOW TRULY OR FALSELY DO THE FOLLOWING STATEMENTS REFER TO YOUR CURRENT CONDITION?	DEFINITELY FALSE	MOSTLY FALSE	DON'T KNOW	MOSTLY TRUE	DEFINITELY TRUE
33. I SEEM TO GET SICK A LITTLE EASIER THAN OTHER PEOPLE					
34. I AM AS HEALTHY AS ANYONE I KNOW					
35. I EXPECT MY HEALTH TO GET WORSE					
36. `MY HEALTH IS EXCELLENT					

Source : http://www.rand.org/health/surveys_tools/

PAIN PLEASE ASSESS THE DEGREE OF PAIN	GRADING SCALE				
	1	**2**	**3**	**5**	**5**
RATED ON A SCALE OF 10 – 100 % HOW MUCH OF THE TIME PAIN IS PRESENT >>	10% 20%	30% 40%	50% 60%	70% 80%	90% 100%
	Intermittent	Occasionally	Often	Constant	Excruciating all
• FREQUENCY					
	Minimal	Slight	Moderate	Marked	Excruciating
• INTENSITY					
	Ignored	Can ignore	Cannot ignore	Impacts ADL	Excruciating
• SEVERITY					
	None	Occasionally	Constantly	> 2 oral meds	Injected
• MEDICATION REQUIREMENTS					
	Normal	Relative norm	Mild impaired	Impacts ADL	Unable ADL
• ACTIVITIES OF DAILY LIVING (SEE ATTACHED RATING SCHEDULE)					
	GP	GP / Specialist	Specialist	Pain clinic	Admission
• LEVEL OF CARE REQUIRED					
	NAD	Early	Easily noted	Severe	Extreme
• RADIOLOGICAL FINDINGS					
	NAD	Early Objective	Objective	Solid Objectiv	Severe Objectiv
• CLINICALLY OBJECTIVE EVIDENCE					

PAIN RELIEVED BY

- ☐ LYING ON BACK
- ☐ ON BACK, KNEES BENT
- ☐ CHANGING POSITION
- ☐ ON LEFT SIDE
- ☐ ON RIGHT SIDE
- ☐ WALKING
- ☐ STANDING
- ☐ SITTING
- ☐ BRACE
- ☐ CORSET
- ☐ KIDNEY BELT
- ☐ NECK COLLAR

PREVIOUS PAIN MANAGEMENT

- ☐ TRIGGER POINT INJECTION
- ☐ NSAID (CORTISONE)
- ☐ PCA PUMP
- ☐ EPIDURAL
- ☐ OTHER:____
- ☐ FACET BLOCK
- ☐ NEUROLYSIS
- ☐ RHIZOTOMY

PREVIOUS SURGERY

- ☐ FUSION
- ☐ TOTAL DISC REPLACEMENT
- ☐ DECOMPRESSION
- ☐ LAMINECTOMY / DISCECTOMY
- ☐ NERVE ABLATION
- ☐ OTHER:____