Dr Hina Neurosurgery Inc
Dr. Thembani S. Hina
SPECIALIST NEUROSURGEON, ENDOVASCULAR SUBSPECIALIST
Practice Number: 128 1259

Reception: Admin@drhinaneuro.com
021 441 0567 / 021 441 0568
Suite 204, The Link Building,
Netcare Christiaan Barnard Memorial Hospital,
11 DF Malan Street, Foreshore, Cape Town, 8001

MEDICAL HISTORY QUESTIONNAIRE

Please complete before your consultation. This helps Dr Hina understand your condition. Leave blank anything you are unsure of.

1. PATIENT DETAILS

Title	Surname	First name(s)

SA ID / Passport number	Date of birth	Age	Date completed

Sex: ☐ Male ☐ Female

Handedness: ☐ Right ☐ Left ☐ Both

Occupation	Referring doctor	Family doctor (GP)

2. REASON FOR YOUR VISIT

What is the main problem you would like help with?

When did it start?	How did it start? (e.g. suddenly, gradually, after an injury / accident)

Since it started, is it: ☐ Getting better ☐ Getting worse ☐ Staying the same ☐ Coming and going

Related to: ☐ Work injury ☐ Motor vehicle accident ☐ Fall ☐ Sports injury ☐ None ☐ Other: _____

3. PAIN

Where is your pain? ☐ Head ☐ Neck ☐ Upper back ☐ Lower back ☐ Arm(s) ☐ Leg(s) ☐ Other: _____

Which side? ☐ Left ☐ Right ☐ Both ☐ Middle

Pain feels: ☐ Sharp ☐ Dull / aching ☐ Burning ☐ Shooting / electric ☐ Throbbing ☐ Pins and needles

Pain right now: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *(0 = none, 10 = worst)*

Pain at its worst: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *(0 = none, 10 = worst)*

What makes it worse?	What makes it better?

4. SYMPTOMS

Have you noticed any of the following?

Headaches	☐ Yes	☐ No	Dizziness / vertigo	☐ Yes	☐ No	Fainting / blackouts	☐ Yes	☐ No
Seizures / fits	☐ Yes	☐ No	Blurred or double vision	☐ Yes	☐ No	Hearing changes / ringing	☐ Yes	☐ No
Memory problems	☐ Yes	☐ No	Confusion / poor concentration	☐ Yes	☐ No	Speech difficulty	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No	Numbness / tingling	☐ Yes	☐ No	Weakness in arms	☐ Yes	☐ No
Weakness in legs	☐ Yes	☐ No	Poor balance / falls	☐ Yes	☐ No	Dropping things / clumsy hands	☐ Yes	☐ No
Loss of bladder control	☐ Yes	☐ No	Loss of bowel control	☐ Yes	☐ No	Groin / buttock numbness	☐ Yes	☐ No
Sexual dysfunction (new)	☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No	Fever / night sweats	☐ Yes	☐ No

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Please describe any 'Yes' answers (where, how long, how often)

5. TREATMENT AND TESTS SO FAR

Physiotherapy	☐ Yes ☐ No	Chiropractic / biokinetics	☐ Yes ☐ No	Pain injections / blocks	☐ Yes ☐ No
Pain medication	☐ Yes ☐ No	Previous brain / spine surgery	☐ Yes ☐ No	Wear a brace / collar	☐ Yes ☐ No

Details (what, when, did it help?)

Scans already done: ☐ X-ray ☐ CT scan ☐ MRI scan ☐ Angiogram ☐ Nerve conduction / EMG ☐ EEG

Where and when were scans done? (please bring the images and reports)

6. PAST MEDICAL HISTORY

High blood pressure	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Heart disease	☐ Yes ☐ No
Stroke / TIA	☐ Yes ☐ No	Brain aneurysm / bleed	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Asthma / COPD	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Thyroid disease	☐ Yes ☐ No	Bleeding / clotting disorder	☐ Yes ☐ No	DVT / pulmonary embolism	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Arthritis / osteoporosis	☐ Yes ☐ No	Depression / anxiety	☐ Yes ☐ No	Sleep apnoea	☐ Yes ☐ No

Other illnesses / details

7. SURGICAL HISTORY

Operation	Year	Hospital / surgeon	Any complications?

Anaesthetic problems (self)	☐ Yes ☐ No	Anaesthetic problems (family)	☐ Yes ☐ No	Implants / pacemaker	☐ Yes ☐ No

8. CURRENT MEDICATION

Medication name	Dose	How often	Reason

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Blood thinners (warfarin, aspirin, clopidogrel, etc.) ☐ Yes ☐ No

9. ALLERGIES

Known allergies: ☐ None known ☐ Medication ☐ Latex ☐ Iodine / contrast dye ☐ Plaster / dressings ☐ Food

Allergy details and reaction

10. FAMILY HISTORY

Has any blood relative (parent, brother, sister, child) had any of the following?

Brain aneurysm / bleed	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Brain tumour	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Dementia	☐ Yes	☐ No	Multiple sclerosis	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No	Problems with anaesthesia	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

Details (which relative, which condition)

11. SOCIAL HISTORY

Smoking: ☐ Never ☐ Former ☐ Current

If current / former: amount per day and number of years	Year stopped

Alcohol: ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily

Recreational drug use	☐ Yes	☐ No	Currently driving	☐ Yes	☐ No	Live alone	☐ Yes	☐ No

Work status: ☐ Working full duties ☐ Light duties ☐ Off work due to this problem ☐ Retired ☐ Unemployed ☐ Student

Date last worked (if off work)	Height (cm)	Weight (kg)	Pregnant? (if applicable)

12. DAILY FUNCTION

How much does your condition affect you? (tick one per row)

	Not at all	A little	Moderately	Severely	Unable
Walking	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Personal care (washing, dressing)	☐	☐	☐	☐	☐
Work / household tasks	☐	☐	☐	☐	☐
Lifting / carrying	☐	☐	☐	☐	☐
Social / leisure activities	☐	☐	☐	☐	☐

Walking distance before you must stop	Walking aid used (stick, crutches, walker, wheelchair)

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13. ANYTHING ELSE?

Is there anything else you would like Dr Hina to know, or any questions you want answered at this visit?

DECLARATION

I confirm that the information above is true and complete to the best of my knowledge. I consent to Dr Hina Neurosurgery Inc using this information for my assessment and treatment, in accordance with the Protection of Personal Information Act (POPIA), 2013.

Patient (or guardian) full name	Signature	Date

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