

**PERSONAL DETAILS**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 I.D.: \_\_\_\_\_ Tel: \_\_\_\_\_  
 Name of GP/Physician & contact details: \_\_\_\_\_  
 \_\_\_\_\_  
 Emergency contact name and telephone number: \_\_\_\_\_  
 \_\_\_\_\_

**WORK PLACE HEALTH QUESTIONNAIRE (CONFIDENTIAL INFO)**

*Please read the questions carefully and answer each one as honestly as you can.*

Condition	Yes	No	Details <i>If yes please indicate severity &amp; if you require chronic medication</i>
<b>Family history of any of the following:</b> Heart attack, coronary artery disease, angina, bypass surgery, diabetes, stroke or cancer			
<b>Conditions of the lungs</b> <ul style="list-style-type: none"> <li>○ Asthma (moderate – severe)</li> <li>○ Chronic Obstructive Pulmonary Disease (COPD), emphysema, chronic bronchitis and cystic fibrosis</li> </ul>			
<b>Do you smoke? Or previously smoked?</b>			How many cigarettes a day? When did you quite?
<b>Chronic kidney disease</b>			Do you require dialysis treatment ?
<b>Diabetes</b> <ul style="list-style-type: none"> <li>○ Type 1</li> <li>○ Type 2</li> </ul>			
<b>Haemoglobin disorder</b> <ul style="list-style-type: none"> <li>○ Sickle cell disease</li> <li>○ Thalassemia</li> </ul>			
<b>Are you immunocompromised?</b> <b>Conditions and treatment that may cause a weakened immune system include:</b> <ul style="list-style-type: none"> <li>○ Cancer treatment</li> <li>○ Bone marrow or organ transplantation</li> <li>○ HIV with a low CD4 count or not on treatment</li> <li>○ Prolonged use of corticosteroids and other immune weakening medication used for the treatment of autoimmune disease such as rheumatoid arthritis</li> </ul>			
<b>Liver disease</b> Cirrhosis			
<b>Age</b> 60 years of age and older			
<b>Heart conditions</b> <ul style="list-style-type: none"> <li>○ Including heart failure</li> <li>○ Coronary artery disease</li> <li>○ Congenital heart disease Cardiomyopathies</li> <li>○ Pulmonary hypertension</li> </ul>			
<b>Severe obesity (BMI &gt;40)</b> Where BMI is calculated as <b>Weight (kg)/Height<sup>2</sup>(m)</b>			
<b>Are you pregnant?</b>			



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### CONSENT

I, \_\_\_\_\_, the undersigned, understand and declare that:

- I have disclosed all my medical conditions, medication and any other related relevant information.
- I understand that all information given herein will be treated with the utmost confidentiality.
- I give this consent freely and declare that it was not made under duress.

SIGNED: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_