Cape Town Residence

20 Bellevue Street
Gardens, 8001
Email: admin@theywct.co.za
Website: www.theywct.co.za

Tel: (021) 423 3711

MEDICAL FORM

(to be completed by the family doctor)

PATIENT'S DETAILS			
Full Name			
Date of Birth			
Height		Weight	

PATIENT HISTORY		
Has the applicant had any notifiable diseases?	YES	NO
If yes, please specify:		
Does the applicant have any chronic ailments?	YES	NO
If yes, please specify:		
Does the applicant have any allergies?	YES	NO
If yes, please specify:		
Is the applicant undergoing any current treatment or taking any prescription drugs?	YES	NO
If yes, please specify:		

DOCTOR'S DETAILS	
Full Name	
Address of Medical Practice	
Medical Practice Registration Number	
Contact number	
Email address	

________________________________ ________________________________

Signature Date