



B **INTAKE FORM**
DISEASE MANAGEMENT FORM
ADULT INTAKE FORM

Forward to: MyHealth Administrators, Maerua Office Park, Robert Mugabe Avenue, Windhoek
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Administrators of	Vitality Private Medical Aid Funds RCC Renaissance Medical Aid Employer Groups	Aids Outreach Programme Namibia Medical Care Bankmed Namibia	Metropolitan Workplace Solutions
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1. Patient Surname..... First Name..... Date of birth.....

2. Consultation date..... Medical Aid..... Medical Aid No.....

3. Male Female

4. Significant past Medical history, including opportunistic infections etc over the past 6 months

Date	Condition	Treatment Received	Outcome

5. Presenting Symptoms (please tick)

General <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Night sweats <input type="checkbox"/> Pedal swelling <input type="checkbox"/> Yellow eyes <input type="checkbox"/> Weight loss ENT/Mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth sores <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Blocked nose	Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Convulsions <input type="checkbox"/> Numbness <input type="checkbox"/> Confusion Skin/Musculoskeletal <input type="checkbox"/> Rashes <input type="checkbox"/> Lumps <input type="checkbox"/> Loss of fat	Urogenital <input type="checkbox"/> PV bleeding <input type="checkbox"/> PV discharge <input type="checkbox"/> Genital ulcers <input type="checkbox"/> Genital growths <input type="checkbox"/> Painful urination <input type="checkbox"/> Urethral discharge Respiratory <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty breathing	Gastrointestinal <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Anal bleeding Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations
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6. General examination Wt.....kg Ht.....cm T.....°C BP.....mmHG
 Peripheral lymphadenopathy Jaundice Pallor Cyanosis Peripheral oedema

7. Baseline physical examination (very important to enable MyHealth to track sites of OI's and toxicities)

Nervous.....

ENT/Mouth.....

Resp/Chest.....

Cardiovascular.....

Abdomen.....

Urogenital.....

Anorectal.....

Skin/Musculoskeletal.....

8. Baseline Laboratory results (please attach copies of all baseline tests)

Date	Test	Result	Date	Test	Result
	HIV 1 and 2			Glucose	
	CD4 + %			HBsAg	
	Viral load			HB	
	ALT			Creatinine	

<p>9. Pregnant?</p> <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> LMP..... <input type="checkbox"/> EDD.....	<p>10. Contraceptives use</p> <input type="checkbox"/> Oral <input type="checkbox"/> Injectables <input type="checkbox"/> None	<p>11. Previous ARVs exposure</p> <input type="checkbox"/> None <input type="checkbox"/> HAART <input type="checkbox"/> PMTCT <input type="checkbox"/> PEP (occupational exposure/rape?)
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12. Specify regimen if any of (11) above is applicable.....

