



PATIENT DEMOGRAPHIC FORM

SERVICE POINT INFORMATION

Province: \_\_\_\_\_ District/Metro Council: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Facility File Number: \_\_\_\_\_ Visit date 

dd	mm					yy			

PATIENT INFORMATION

Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date of birth: 

dd	mm					yy			

Id No: 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 Sex:  M  F Adult (≥15 yrs)  Child (<15 yrs)

Citizenship: \_\_\_\_\_

Postal Address: \_\_\_\_\_ Physical Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Te No: \_\_\_\_\_

If child, details of next of kin or primary care giver:  Parent  Guardian

Name: \_\_\_\_\_

Surname: \_\_\_\_\_ Tel No: \_\_\_\_\_

EDUCATION

POPULATION GROUP

- |  |                                     |                                  |                                   |
|--|-------------------------------------|----------------------------------|-----------------------------------|
| Not yet schooling <input type="checkbox"/> | Preschool <input type="checkbox"/>  | African <input type="checkbox"/> | Coloured <input type="checkbox"/> |
| No education <input type="checkbox"/>      | Grade 0-5 <input type="checkbox"/>  | White <input type="checkbox"/>   | Indian <input type="checkbox"/>   |
| Grade 6-7 <input type="checkbox"/>         | Grade 8-12 <input type="checkbox"/> | Other <input type="checkbox"/>   |                                   |
| Higher <input type="checkbox"/>            |                                     |                                  |                                   |

MARITAL STATUS (patient or primary care giver)

EMPLOYMENT (patient or primary care giver)

- |                                    |                                     |  |
|------------------------------------|-------------------------------------|--|
| Single <input type="checkbox"/>    | Married <input type="checkbox"/>    | Employed <input type="checkbox"/>      |
| Separated <input type="checkbox"/> | Divorced <input type="checkbox"/>   | Unemployed <input type="checkbox"/>    |
| Widowed <input type="checkbox"/>   | Cohabiting <input type="checkbox"/> | Self-employed <input type="checkbox"/> |

IS THE PATIENT OR PRIMARY CAREGIVER RECEIVING ANY OF THE FOLLOWING SOCIAL ASSISTANCE/GRANTS

- |                  |                              |                             |                       |                              |                             |
|------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| Pension          | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Child support grant   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Disability grant | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Other (specify) _____ |                              |                             |

DATA CAPTURE

Name and Surname of data capturer: \_\_\_\_\_ Capture date: \_\_\_\_\_