

MEDICAL EXAMINATION FORM

For Applicant/Dependant (Tobe filled in by a Medical Officer)

N.B A separate form must be used for each person

| Surname | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|------|---------|---|---|---|---|---|---|---|---|---|-----|------|-------|-----|--|--|--|--|
| First Name(s) | | | | | | | | | | | | | | | | | | | | | |
| Gender | М | F | Date | of Birt | h | D | D | М | М | Υ | Υ | Υ | Υ | Age | next | birth | day | | | | |
| Relationship of dependant to principal member | | | | | | | | | | | | | | | | | | | | | |

| Do you have, or have you ever had any of the following? | Circle Answer | If yes give full Details including dates |
|---|------------------|---|
| Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure heart murmur, angina, heart attack or any any other cardiac/vascular disorder? | Yes No | |
| Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder? | Yes No | |
| Nephritis, prostrate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder? | Yes No | |
| Diabetes, sugar in blood/urine, glandular, disorder, goitre or any other endocrine disorder. | Yes No | |
| Conditions of joints or spine including rheumatism, arthri, neck or back disorder? | Yes No | |
| Any lumps, growths (benign or malignant) cancer, Hodgkin's disease, leukema, skin cancer, lesions or any other related problmes? | Yes No | |



(Medical Examination Form) Continued......

| 7. | Ulcers (gastric or duodenal hiatus, hiatus hernia) gall bladder problems, hepatitis dysentery, gastro-intestinal or abdominal obstructions or any other related disorders | Yes | No | |
|-----|--|---------|----|--|
| 8. | Nervous or mental complaint e.g. epilespsy convulsions, dizziness, blackouts, paralysis meningitis,anxiety states, dpression, alcoholism narcotism or any other related disorders | Yes | No | |
| 9. | Ear, eye, nose, throat problem, icluding ear discharge, hearing loss, defective vision tonsillitis, groments, injuries, or any other ENT disorders? | Yes | No | |
| 10. | Diseases of the reproductive system e.g infertility, ovarian cysts, uterine fibroids, abnormality of pregnancy or confinement or any other related reproductive system disorder? | Yes | No | |
| 11. | Expecting or planning to have a baby? state the dates. | Yes | No | |
| 12. | Sexually transmitted diseases e.g sysphilis. gonorrhoea, HIV /AIDS relatedilliness or any other sexually transmitted diseases? | Yes | No | |
| 13. | Any physical disabilities or injuries? | Yes | No | |
| 14. | Any congenital disease/disability? | Yes | No | |
| 15. | Any special dental treatments e.g crown bridge prothodontic and orthodontic appliances or any other dental problems? | Yes | No | |
| 16. | Alcoholism, narcotism or any substance abuse problem? | Yes | No | |
| 0 | bjectives | | | |
| 17. | BPHeight | _Weight | kg | |
| 18. | Stethoscopia pulmonis (auscultation lungs) | | | |
| 19. | Stethoscopia Cordis (auscultation heart) | | | |
| 20. | Any special abnormality/observation | | | |
| | | | | |

(PLEASE TURN OVER)



(Medical Examination Form) Continued.....

| (Medical Examination Form) Continued | | | | | | | |
|---|----------------------------|--|--|--|--|--|--|
| 21. If 'yes' to question (12) please inform patient to conta Administrator at 3184210. | act Senior Chronic Ailment | | | | | | |
| I hereby declare that the particulars given above are to the best of my knowledge true and correct; | | | | | | | |
| Doctor's singanture: | Applicants singanture: | | | | | | |
| Date: | | | | | | | |