Once filled in please email the completed form and supporting documents to membership@bomaid.co.bw OR fax to +267 3184152/ 230 OR drop off at your nearest Bomaid office

Bomaid
Health & Happiness at heart

MEDICAL EXAMINATION FORM

For Applicant/Dependant (To be filled in by a Medical Officer)
NB: A separate form must be used for each person

Membership Number										Principal Members' ID/Passport Number									

Principal Member's details

Surname												First Name												

Details of member being added (Relationship to Principal Member)

Self ◯ Spouse ◯ Daughter ◯ Son ◯ Mother ◯ Father ◯ Mother in Law ◯ Father in Law ◯

Surname												First Name												

Gender	M ◯	F ◯	Date of Birth	D	D	M	M	Y	Y	Y	Y	ID/Passport Number									

Do you have, or have you ever had any of the following?		Circle Answer		If you've indicated 'Yes' please state the condition below the respective question
1	Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure, heart murmur, angina, heart attacks or other cardiac/vascular disorder?	Yes	No	
2	Difficulty when breathing, persistent cough, tuberculosis, asthma, bronchitis pneumonia, croup or any other related respiratory disorder?	Yes	No	
3	Nephritis, prostrate problems, kidney stone, congenital kidney disorder, albumen in urine, uraemia or any other urinary/kidney disorder?	Yes	No	
4	Diabetes, sugar in blood/urine, glandular, disorder, goitre or any other endocrine disorder?	Yes	No	
5	Conditions of joints or spine including rheumatism, arthritic, neck or back disorder?	Yes	No	
6	Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukaemia, skin cancer, lesion or any other related problems?	Yes	No	
7	Ulcers (gastric or duodenal hiatus, hiatus cancer, lesion or any other related problems dysentery, gastro-intestinal or abdominal obstructions or any other related disorders?	Yes	No	
8	Nervous or mental complaint e.g. epilepsy convulsions, dizziness, blackouts, paralysis meningitis, anxiety states, depression, alcoholism meningitis, anxiety states, depression, alcoholism	Yes	No	
9	Ear, eye, nose, throat problem, including ear discharge, hearing loss, defective vision tonsillitis, grommets', injuries, or any other ENT disorders?	Yes	No	

(PLEASE TURN OVER)

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? If you have indicated 'yes' please state the expected delivery dates	Yes	No	
12	Sexually transmitted diseases e.g syphilis, gonorrhoea, HIV /AIDS related illness 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. crown bridge prosthodontic and orthodontic appliances or any other dental problems?	Yes	No	
16	Alcoholism, narcotism or any substance abuse problem?	Yes	No	

Objectives

17	BP								Height (in cm)				c	m	Weight (in kgs)				k	g

18 Stethoscopia pulmonis (auscultation lungs)

19 Stethoscopia Cordis (auscultation heart)

20 Any special abnormality/observation

21 If 'yes' to question (12) please inform patient to contact Senior Chronic Ailment Administrator at 3633105/110

I hereby declare that the particulars given above are, to the best of my knowledge true and correct;

Doctor's Signature		Applicant's Signature	

Date Signed	D	D	M	M	Y	Y	Y	Y	Principal Member's Cellphone No.													