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The medical aid you can trust

Medical History Form B3

Principal Member	Depandant	Additional Dependant	Membership Number

Surname																								
Firstname(s)																								

Gender	M	F	Date of Birth	D	D	M	M	Y	Y	Y	Y	Age next birthday												

Relationship to Principal Member																								

Do you have, or have you ever had any of the following?	Circle Answer	If yes give full Details including dates
1. Shortness of breath, palpitations, raised cholesterol, stroke, raised blood pressure heart murmur, angina, heart attack or any any 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, arthri, neck or back disorder?	Yes No	
6. Any lumps, growths (benign or malignant cancer, Hodgkin's disease, leukema, skin cancer, lesion or any other related problmes?	Yes No	
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	

(PLEASE TURN OVER)

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Form B3 (Medical History) Continued.....

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. crown bridge prothodontic and orthodontic appliances or any other dental problems? — Yes No

16. When last did you see your doctor and for what reason?

17. Do you have any chronic conditions that may need medical attention within the next twelve months?

18. List details of medications used in the last twelve months and related conditions

19. State the name of your usual Medical Officer or any other Practitioner you have consulted to whom reference may be made.

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

Applicants singanture: _____ Date: _____

ID No: _____ Cell: _____

Email address: _____