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
The medical aid you can trust

Medical History Form B3

Membership Number									

Principal Member's details

Surname		First Name	

Details of member being added (Relationship to Principal Member)

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

Surname		First Name	
Gender	Tick appropriate box	Male ◯	Female ◯

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

	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 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;

Applicant's Signature		Date Signed	D	D	M	M	Y	Y	Y	Y
ID/ Passport Number		Cellphone Number								
Email Address										