

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

Medical History Form B3

Membership Number																			
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Principal Member's details

Surname																					First Name																			
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Details of member being added (Relationship to Principal Member)

Spouse Daughter Son Mother Father Mother in Law Father in Law

Surname																					First Name																			
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Gender	<input type="checkbox"/> Tick appropriate box	Male	Female	Date of Birth	D	D	M	M	Y	Y	Y	Y	Age next birthday			
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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
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|---|--|-----|----|-------|
| 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, prostate 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)

