SIZWE HOSMED
MEDICAL SCHEME
Your choice for quality care

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MEDICAL QUESTIONNAIRE FORM

PLEASE COMPLETE APPROPRIATELY ALL THE SECTIONS BELOW IN FULL

SECTION A: MEMBER DETAILS

Title: Mr/Mrs/Miss		Initials		First name	
Surname		Gender M F		Identity no.	
Tel. no. (h)		(w)		(Cell)	
Email					
Residential address					
				Postal code	
Postal address					
				Postal code	
Race (please tick)	African	Coloured	Indian/Asian	White	
Preferred method of communication (please tick)	Email ☐	SMS ☐	Post ☐		

SECTION B: MEDICAL QUESTIONS

Do you or your depandants have, or ever had the following? If "yes" state full details below (complete all questions):				
1. Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes		Name
2. High blood pressure, chronic headache or disease of the blood vessels including cholesterol or circulatory disorder?	No	Yes		
3. Any respiratory or lung trouble,e.g. asthma, bronchitis, persistent cough, tuberculosis?	No	Yes		
4. Any disorder of the digestive system, gall bladder or liver e.g. actual or suspected gastric or duodenal ulcer, recurrent indigestion or hiatus hernia?	No	Yes		
5. Disease or disorder of the kidneys, bladder or reproductive organs, e.g. albumin in urine, stones, prostatitis or infertility?	No	Yes		
6. Any nervous or mental complaint, e.g. epilepsy, black-outs, paralysis, anxiety state or depression, alcoholism or narcotism?	No	Yes		
7. Ear, eye, nose or throat disorder, e.g. ear discharge, defective vision, tonsilitis and sinus problems?	No	Yes		
8. Disorder or disease of muscles, bones, joints, limbs, spine, e.g. rheumatism, arthritis, gout, slipped disc or other back trouble?	No	Yes		
9. Diabetes, acne or skin problems, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes		
10. Cancer, growth or tumour of any kind?	No	Yes		
11. Any tropical disease, e.g. Bilharzia?	No	Yes		
12. Any other illness, disorder, operation, disability or injuries from any accident or HIV/Aids infection?	No	Yes		
13a. Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement, e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes		
13b. Are you now pregnant? If "Yes", how many months? _____ If "Yes" is this a multiple birth?	No	Yes		
14. Any special dental treatment, e.g. crowns, bridges, orthodontic, etc?	No	Yes		
15. Any illness or physical defect likely to necessitate medical or dental treatment, e.g. headaches, lumps, orthodontic work etc.?	No	Yes		
16. Do you expect any medical or dental treatment within the next three months?	No	Yes		
17. Do you or your dependants have a medical condition not disclosed?	No	Yes		
18. Detail all medication used by applicant and dependants during the last 2 years, as well as all Pathology and Radiology tests.				

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