

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 | | 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 dependants have, or ever had the following? If "yes" state full details below (complete all questions): | | | | Name |
|---|----|-----|--|------|
| 1. Any disorder of the heart e.g. rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations? | No | Yes | | |
| 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, tonsillitis 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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