

CONFIDENTIAL

MEDICAL EXAMINATION FORM for Applicant/Dependant
(To be filled in by a Medical Officer)

N.B A separate form must be used for each person

Surname: _____ **First name:** _____

Initial(s): _____ **Sex:** _____ **Date of birth:** _____ **Age next birthday:** _____

Relationship of dependant to principal member: _____

SUBJECTIVE

IS/HAS THE APPLICANT SUFFERED / SUFFERING FROM ANY OF THE FOLLOWING:	ANSWER YES/NO	IF ANY ANSWER IS IN THE AFFIRMATIVE (YES) GIVE FULL DETAILS HEREUNDER INCLUDING DATES
1. Shortness of breath, Palpitations, Raised Cholesterol, Stroke, Raised Blood Pressure, Heart Attack or any other Cardiac / Vascular Disorder?		
2. Difficulty when breathing, persistent cough, Tuberculosis, Asthma, Bronchitis, Pneumonia, Cough or any other related Respiratory Disorder?		
3. Nephritis, Prostate Problems, Kidney Stone, Congenital Kidney Disorder, Incontinence, Albumen in Urine, Ureamia or any other Urinary /Kidney Disorder?		
4. Diabetes, Sugar in Blood/Urine, Glandular Disorder, Goitre or any other related Endocrine Disorder?		
5. Conditions of Joints or Spine including Rheumatism, Arthritis, Neck or Back Disorder?		
6. Any Lumps, Growth (Benign or Malignant), Cancer, Hodgkins Disease, Leukemia, Skin Cancer, Lesions or any Other problems?		

7. Ulcers, (Gastric/Duodenal) Hiatus Hernia, Gall Bladder problems, Hepatitis, Dysentery, Intestinal/Bowel obstruction or Any other related Gastro-intestinal or Liver Disorder?		
8. Nervous or Mental complaint e.g Epilepsy, Fits, Convulsions, Dizziness, Blackouts, Paralysis, Meningitis, Anxiety States or Depression?		
9. Ear, Eyes, Nose, Throat including Ear Discharge, Hearing Loss, Defective Vision, Tonsillitis, Grommets, Injuries or any Other ENT Disorder?		
10. Diseases of Reproductive System e.g Infertility, Ovarian Cysts, Uterine Fibroids, Abnormality of Pregnancy or Confinement or any other related reproductive Disorder?		
11. Expecting a baby or planning to have a baby? (State the dates)		
12. Sexually transmitted Diseases e.g Syphilis, Gonorrhoea, AIDS/HIV related illness or any other sexually transmitted diseases?		
13. Any physical disability or injuries?		
14. Any Congenital Disorders?		
15. Any special Dental treatment e.g Crown, Bridge, Prothonic and Orthodontic Appliances or any other Dental problems?		
16. Alcoholism, Narcotism or any substance abuse problem?		

OBJECTIVE

17. BP _____ Height _____ Weight: _____ kg

18. Stethoscopia pulmonis (auscultation lungs) _____

19. Stethoscopia Cordis (auscultation heart) _____

20. Any special abnormality/observation _____

21. If 'yes' to questions (1) and /or (2)

Chest X-ray findings (may attach copy of report) _____

22. If 'yes' to question (12) please inform patient to contact Senior Chronic Ailment Administrator at 3184210.

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

Doctor's Signature Applicant's Signature

Date: