

FORM B3 (MEDICAL HISTORY) CONTINUED.....

- 8. Nervous or mental complaint e.g. epilepsy, convulsions, dizziness, blackouts, paralysis, meningitis, anxiety states, depression, alcoholism, narcotism or any other related disorders? 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
- 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? state the dates YES/NO
- 12. Sexually transmitted diseases e.g. syphilis, gonorrhoea, HIV /AIDS related illnesses 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.g. crown, bridge, prothodontic 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;

Applicants Signature.....Date.....