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

Bomaid
The medical aid you can trust

Medical History Form B3

Membership Number

Principal Member's details

Surname | First Name

Details of member being added (Relationship to Principal Member)

Spouse ◯ Daughter ◯ Son ◯ Mother ◯ Father ◯ Mother in Law ◯ Father in Law ◯

Surname | First Name

Gender | Tick appropriate box | Male ◯ | Female ◯ | Date of Birth D D M M Y Y Y Y | Age next birthday

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
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, prostrate 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)

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? If you have indicated 'yes' please state the expected delivery dates Yes ☐ No ☐

12 Sexually transmitted diseases e.g syphilis, gonorrhoea, HIV /AIDS related illness 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. crown bridge prosthodontic and orthodontic appliances or any other dental problems? Yes ☐ No ☐

16 Are you a smoker? 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;

Applicant's Signature		Date Signed	D D M M Y Y Y Y
ID/ Passport Number		Cellphone Number	
Email Address			