

Name Mr./Mrs./Miss/Master _____

Date of birth _____ Company _____

Postal Address _____

CONFIDENTIAL MEDICAL HISTORY

To be completed by all applicants for Hospital Membership.

Please read carefully, and complete all the required information by placing a tick in the relevant box.

If the answer is “Yes” please give more details in the space provided. Failure to disclose information, or giving incorrect information, can result in immediate cancellation of the Membership.

PLEASE TICK YES or NO IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

	DISEASE OR CONDITION	YES	NO	DETAIL
1	HEART DISEASE e.g. THROMBOSIS, HEART ATTACK			
2	CONGENITAL HEART DISEASE, RHEUMATIC FEVER			
3	RAISED BLOOD PRESSURE			
4	RAISED CHOLESTEROL			
5	ASTHMA			
6	CHRONIC BRONCHITIS, EMPHYSEMA, CPD			
7	TUBERCULOSIS			
8	LIVER DISEASE, JAUNDICE			
9	GALL BLADDER DISEASE (GALL STONES)			
10	GASTRIC / DUODENAL ULCER			
11	HIATUS HERNIA, INGUINAL HERNIA			
12	ANY OTHER DIGESTIVE DISORDER			
13	KIDNEY DISEASE e.g. STONES, NEPHRITIS (INFECTION)			
14	BLADDER or PROSTATE DISEASE			
15	TROPICAL DISEASE			
16	EPILEPSY or STROKE			
17	ANY OTHER NEUROLOGICAL DISORDER			
18	DIABETES			
19	THYROID DISEASE			
20	BACK, NECK, JOINT PROBLEMS, ARTHRITIS or GOUT			
21	ANY MUSCULAR or PHYSICAL DISABILITY			
22	PSYCHIATRIC DISORDER e.g. CLINICAL DEPRESSION			
23	MALIGNANT TUMOURS, CANCER including Leukaemia, Hodgkin’s Disease, Lymphoma, Skin cancer etc.			
24	HAVE YOU EVER HAD AN HIV TEST?			
25	HAVE YOU EVER HAD A HEPATITIS B TEST?			
26	FOR LADIES – ARE YOU PREGNANT? IF YES, PLEASE STATE EXPECTED DATE OF DELIVERY OF BABY			
27	DO YOU HAVE ANY ALLERGIES e.g. FOOD, MEDICATION, BEES, ANYTHING ELSE?			
28	HAS YOUR WEIGHT CHANGED BY MORE THAN 5kgs IN THE LAST YEAR?			
29	IS THERE ANY FACTOR NOT MENTIONED ABOVE THAT MAY AFFECT YOUR HEALTH IN THE NEXT YEAR?			

Please note that information must be disclosed. If there is insufficient space above, please attach a separate sheet with other information & any relevant medical reports.

PLEASE READ CAREFULLY

I declare that any false statement in the above questionnaire or non-disclosure of information will render the membership null & void.

I understand that any of the above declared conditions may be excluded from benefit for an initial period of time after joining cfb Hospital. This is called the “Waiting Time” or “Exclusion Period”, see “Guidelines for Membership” Rules booklet for details. I acknowledge that treatment for any excluded conditions will be fully paid to cfb by me.

I understand that my membership will be accepted on payment of the subscription, but the above conditions may not be entitled to benefit until authorised by the CEO of cfb Medical Centre.

Signature of Member.....Date of joining.....