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HEALTH QUESTIONNAIRE

This form is to be completed by each person applying for membership

A. PRINCIPAL MEMBER/DEPENDANT'S DETAILS

Title

Surname | ID Number

First Names | Telephone (H) C O D E

Date of Birth D D M M Y Y Y Y | Fax Number C O D E

Telephone (W) C O D E | Telephone (Cell)

B. ADDRESS DETAILS

Postal Address | **Physical Address**

Postal Code | Postal Code

C. DECLARATION

By signing below I hereby:

- Warrant that the information in this application, whether in my own handwriting or not, is complete and correct.
- Consent to undergo a medical examination at my own expense and realise that I must submit evidence of good health for myself and my dependants and that the benefits may be limited or excluded in respect of any particular ailment, disease, disorder, condition or disability which existed on my admission date, or SUREMED may decline to accept me or any of my dependants.
- I am bound now, and in future, if I am accepted as a Member, to give SUREMED all such information and evidence as SUREMED may from time to time require and to this end authorise the medical practitioner or other provider who has attended to me in the past or who will attend to me in the future to provide SUREMED with such information as SUREMED may require, hereby waiving the provisions of any law or regulation restricting the giving of such information.
- To the extent that I, or my dependants, suffer from any particular ailment, disease, disorder, condition or disability, I shall provide details thereof.
- My doctor (or the doctor of the above mentioned patient who is a minor dependant of mine) may provide personal clinical information on this application form.
- Any information concerning this application will remain confidential at all times.

Signature (Principal Member) ______________________________ **Date** D D M M Y Y Y Y

D. MEDICAL HISTORY

Mark 'Yes' or 'No' with an X

Height | Weight

Do you smoke? Yes No

How often do you have an alcoholic drink? Please mark with X

Are you pregnant? Yes No

If 'yes', how many weeks

Has your weight changed in the last year? Yes No

If 'yes', provide details

Never

Occasional (2-4 times a month or less)

Moderate (2-3 times a week)

Frequent (More than 4 times a week)

If frequent, how many per day

Do you use Chronic Medication? Yes No

Are you aware of any medical condition(s) which could require medical treatment or surgery? Yes No

If 'yes', please state details

Patient Name	

E. CONDITION-SPECIFIC INFORMATION

Have you ever experienced or been treated for, or are currently suffering from any of the following conditions?

	If 'yes', Please mark the appropriate block with an X, or specify the condition	**Mark Y or N**
1. Cardiovascular and/ or Blood disorders	☐ Chest Pain (Angina) ☐ Valve defect ☐ Rheumatic heart fever ☐ Heart attack ☐ Heart murmures ☐ Hypertension (Blood pressure) ☐ Rhythm disorder ☐ Cholesterol ☐ Anaemia ☐ Leukaemia Other, Specify	Y or N
2. Respiratory problems (Lung or breathing)	☐ Difficulty in breathing ☐ Shortness of breath ☐ Persistent cough ☐ Asthma ☐ Croup ☐ Tuberculosis ☐ Bronchitis ☐ Pneumonia ☐ Coughing up blood Other, Specify	Y or N
3. Ear, Nose & Throat	☐ Hearing/speech impairment ☐ Ear Infections ☐ Sinus problems Other, Specify	Y or N
4. Kidney / Urinary System	☐ Blood in urine ☐ Kidney infections ☐ Prostate infections ☐ Kidney failure ☐ Kidney stones ☐ Congenital urinary conditions ☐ Recurrent urinary tract infections Other, Specify	Y or N
5. Gynaecological	☐ Ovarian cysts ☐ Endometriosis ☐ Abnormal pap smears ☐ Fibroid ☐ Enlarged uterus ☐ Menstrual disorders Other, Specify	Y or N
6. Glandular	☐ Diabetes ☐ Addison's disease ☐ Cushing's syndrome ☐ Growth disorders ☐ Disorders of the pituitary gland ☐ Hypo/hyperactive thyroid Other, Specify	Y or N
7. Neurological (Nervous system)	☐ Paralysis ☐ Stroke ☐ Epilepsy ☐ Migraine ☐ Mutiple sclerosis ☐ Brain or spinal cord disorder Other, Specify	Y or N
8. Gastrointestinal	☐ Bleeding ☐ Ulcers ☐ Jaundice ☐ Oesophagitis ☐ Change in bowel habits ☐ Pancreas disorders ☐ Colitis ☐ Gall Bladder ☐ Irritable bowel syndrome Other, Specify	Y or N
9. Musculoskeletal	☐ Joint or spine condition, inluding Rheumatoid/Osteo-arthritis ☐ Neck or Back problems ☐ Recurrent back pain ☐ Ankylosing Spondylitis ☐ Osteoporosis Other, Specify	Y or N
10. Lumps or Growths	☐ Benign tumours ☐ Malignant tumours ☐ Lymph cancer ☐ Leukaemia ☐ Melanoma Other, Specify	Y or N
12. Mental/ Emotional	☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ Attention deficit disorder ☐ Anorexia ☐ Eating disorders ☐ Alzheimers Other, Specify	Y or N
13. Eyes	☐ Glaucoma ☐ Blindness ☐ Impaired vision ☐ Retinitis ☐ Conjunctivitis ☐ Macular degeneration ☐ Cataract Other, Specify	Y or N

Have you ever had, or are you currently undergoing or anticipating any specialised dental treatment? Y or N
(E.g. Orthodontic treatment or removal of impacted wisdom teeth)

Do you have any congential, hereditary or physical disability? Y or N

Do you participate in any hazardous sports or pursuits? E.g. mountain climbing, paragliding, etc. Y or N

Are you aware of any other conditions which may not have been specified on this form? Y or N
If the answer is 'Yes', please supply details below

DETAILS OF CONDITIONS NOT SPECIFIED ABOVE

Condition	Date diagnosed	Duration of Treatment	Treatment

Patient Name

F. MEDICAL PRACTITIONER'S DETAILS

Medical Practitioner's name: Surname ______ Initials ______

Tel ______ Fax ______

Cell ______ Practice number ______

If you have answered 'yes' to any of the previous medical questions, the following details must be provided by your medical practitioner

Diagnosis	Date of onset	Cause	Treatment	Prognosis	Further treatment expected

Medical Practitioner's Signature ______________________ **Date** D D M M Y Y Y Y

Version (07/04)