Medical History Form
cfb Membership

www.cfbmedic.com.zm
membership@cfbmedic.com.zm
T +260 211 255728, C +260 979 700 100
4192, Addis Ababa Drive, Lusaka, Zambia

MEMBER DETAILS

Full Name _____ PMO File Number _____

Date Of birth _____ Mobile Number _____

Email _____

CONFIDENTIAL MEDICAL HISTORY

Please read carefully and answer every question. If you have experienced any of the following, then place a tick in the relevant box .If your answer is Yes to a question, please give full details in the space provided on the next page. If the space provided is insufficient, please attach a separate sheet and relevant medical reports.

No	Disease or Condition	If Yes (✔)
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, Empyema, COPD	
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	Bladder or Prostate Disease	
14	Tropical Disease	
15	Epilepsy or Stroke	
16	Any Other Neurological Disorder	
17	Diabetes	
18	Thyroid Disease	
19	Back, Neck, Joint Problems, Arthritis or Gout	
20	Any Muscular or Physical Disability	
21	Psychiatric Disorder E.g. Clinical Depression	
22	Have You Ever Had a Hepatitis B Test	
23	Have You Ever Had Any Surgery	
24	Any History of Hospital Admission	
25	Kidney Disease E.g. Stones, Nephritis (Infection)	
26	Malignant Tumors, Cancer, Leukemia, Hodgkin's disease, Lymphoma	
27	Are You Pregnant? If Yes, Please State Expected Date of Delivery	
28	Do You Have Any Allergies E.g. Food, medication, bees, etc.	
29	Has Your Weight Changed by More Than 5kg In the Last Year	

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Medical CENTRE
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DETAILS OF MEDICAL CONDITION(S)

No.	Details of Disease or Condition

Disclosure by Applicant:

I declare that I have made a full and complete disclosure about my medical history.

I understand that treatment for any of the above declared conditions may be excluded from membership benefit.

I acknowledge that treatment for any excluded conditions will be fully paid to cfb Medical Centre, by me.

Signature of Applicant _____ Date _____

DIAGNOSIS OF EXCLUDED CONDITIONS

No.	Details of Diesease or Condition

Does the Patient have a Chronic or Pre-Exisiting Condition? ☐ Yes ☐ No

Doctors Signature _____ Date _____

Signature of Applicant _____ Date _____