

MEDICAL ENROLMENT FORM

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Please complete th	ne following information as fully in block letters.		
NAME			
DETAILS			
Date of birth:	Day/ Month/		
Weight	Blood group:		
Business address:			
Residential address:			
Next of Kin:			
Telephone numbers	- Home:		
	- Mobile:		
	- Office:		
✓ Please indicate	e the package:		
	<u> </u>		
Individual Antenatal	Individual Maternity		
PRE-NATAL CARE (QUESTIONNAIRE:		
How many weeks or said you were pregn [] Weeks OR [or nurse	
How many prenatal	visits have you so far done during this pregnancy? []		
Is this your first preg No (specify) Yes []	gnancy?		
If No; Did you have any of had the problem or	f these problems during your last pregnancy? For each item, tick (Yes (No) if you did not.	s) if you	Yes
a High blood sug	ar (diabetes) that started before the pregnancy	110	168
	ar (diabetes) that started during the pregnancy		
c Vaginal bleedin			
	der (urinary tract) infection		
	vomiting, or dehydration		
f Cervix had to b	e sewn shut (incompetent cervix)		in the second

g	High blood pressure, hypertension (including	ng pregnancy-induced	hypertension [PIH]	1			
D	High blood pressure, hypertension (including pregnancy-induced hypertension [PIH], preeclampsia, or toxemia)						
h	Problems with the placenta (such as abruptio placentae or placenta previa)						
i	Labor pains more than 3 weeks before my baby was due (preterm or early labor)						
j	Water broke more than 3 weeks before my baby was due (preterm or early labor)						
J	1	· ·					
k	(premature rupture of membranes [PROM])						
	I had to have a blood transfusion I was hurt in a car accident						
1	I was nurt in a car accident						
MI	you are currently experiencing any of the about the about the about the self and spouse of the about the self and spouse of the self and spouse are suffer the self and self and self are suffer the self and self are suffer the self and self are	-					
		SELF	SPOUSE				
Ι	Diabetes						
(Cancer						
F	Hypertension						
S	Sickle Cell Disease						
F	Bronchitis or Asthma						
F	Rheumatic fever						
N	Malaria						
7	Гuberculosis						
I	Hepatitis B						
A	Any STDs						
A	Any operation in the last 5 years (C/Section)						
 SE	RVICE AGREEMENT						
pac	se Medcare hereby agrees to provide and the Client ckage at the Hospital at its above address.						
	se Medcare hereby warrants that it will diligently procepted scientific methods as and when required to do s		Elient to the best of its abo	ility usir			
	e Client hereby undertakes to pay for any additional contractual terms and benefits.	services rendered to him v	which exceed the financia	l limits			
teri	e Client hereby understands that membership fees mination, for whatever reason occurs within 60 days eived by the Client during that period plus an adminis	s, membership fees are ref	undable, less the cost of				
Sig	gned by the Client:	Date:					
	gned & Stamped by; se Medcare						
		Date:					