Health Club Application Form

CONTACT INFORMATION

Last Name

First Name

Middle Name

Date of Birth

Telephone Number

Email Address

Maiden Name

Marital Status

Single

ADDRESS

Permanent Address

Mailing Address (if different)

NEXT OF KIN

Next of Kin Name

Employer/Company Name

Next of Kin Contact Information

Employer/Company Contact Information

HEALTH INSURANCE

Do you currently have health insurance? If yes, please specify name of insurance company

MEDICAL HISTORY	☐ Food Allergies ☐ Hypertension ☐ Diabetes ☐ Heart Disease ☐ Migraine Headache ☐ Kidney Disease ☐ High Cholesterol ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Lupus ☐ Cancer ☐ Circulatory Disorder ☐ Inflammatory Disorder ☐ Schizophrenia ☐ Bipolar Disorder ☐ Autism ☐ Sinusitis ☐ Allergic Rhinitis ☐ Schizophrenia ☐ Glaucoma ☐ Asthma ☐ Depression ☐ Anxiety ☐ Obesity ☐ Cataracts ☐ Haemorrhoids ☐ Osteoporosis Other
MEDICAL HISTORY DETAILS	If yes to any of the above, please explain below how long you have had this problem and the current treatment for it.
CURRENT MEDICATION	Are you currently on any medications? If yes please list below.
FAMILY HISTORY	Does any medical condition run in your family? (hypertension, diabetes, cancers, etc.)
MEDICATION ALLERGIES	Any known medication allergies? If yes, list below:
SURGICAL PROCE-DURES	Have you ever done any surgical procedure? If yes, please state the date and type of procedure.
DEPENDENTS	Do you wish to add a dependent? If yes, please complete section below. Please note that for each dependent, a separate data sheet has to be completed.

DEPENDENTS

DEPENDENT 1

Full Name

Date of Birth

Relation

DEPENDENT 2

Full Name

Date of Birth

Relation

DEPENDENT 3

Full Name

Date of Birth

Relation

DEPENDENT 4

Full Name

Date of Birth

Relation

SIGNATURE

Signature

Date