

<b>Member Questionnaire</b>														
<i>(To be completed by a Member together with the New Entrant Form and Category Change Form)</i>														
<b>Section 1: Member Identification Details</b>														
First name/s						Surname								
ID number														
Employee number														
<b>Section 2: Member Basic Details</b>														
Height (without shoes)						cm			Weight (in normal clothes)			cm		
Has your weight changed by more than 5kg during the past 6 months?									Yes <input type="checkbox"/>			No <input type="checkbox"/>		
If yes, what was the reason?														
Have you received medical advice to reduce your weight?									Yes <input type="checkbox"/>			No <input type="checkbox"/>		
If yes, what was the reason?														
<b>Section 3: Member Habits/Hobby Details</b>														
How often do you have a drink containing alcohol?						Frequently <input type="checkbox"/>		Seldom <input type="checkbox"/>		Never <input type="checkbox"/>				
Have you received medical advice to reduce or discontinue your alcohol consumption?									Yes <input type="checkbox"/>			No <input type="checkbox"/>		
If yes, what was the reason?														
How often do you smoke?						Frequently <input type="checkbox"/>		Seldom <input type="checkbox"/>		Never <input type="checkbox"/>				
Have you received medical advice to reduce or discontinue smoking?									Yes <input type="checkbox"/>			No <input type="checkbox"/>		
If yes, what was the reason?														
Do you regularly participate in a high-risk sport, hobby or past-time which may expose you to a higher-than-average risk or injury?									Yes <input type="checkbox"/>			No <input type="checkbox"/>		
If yes, give details:														

## MEMBER QUESTIONNAIRE

### Section 4: Medical Details

Have you or any of your family members been diagnosed and treated with any of the medical conditions or disorders listed below, in the last 12 months?

Illness or nature of complaint	Yes/No	Who has the condition? You or family member?	Date diagnosed	Treatment or medication
High Blood Pressure				
Low Blood Pressure				
High Cholesterol				
Diabetes				
Heart Condition				
Asthma				
Tuberculosis				
Chronic Bronchitis				
Anaemia				
Cancer (Please specify where tumor was found)				
Obstructive Bowel Syndrome				
Liver Disease				
Spleen Disease				
Gall Bladder Disease				
Visual Problem				
Hearing Problem				
Depression				
Anxiety Disorder				
Schizophrenia				
Head Injury				
Chronic Headaches				
Suffered from Stroke				
Progressive Tremors or Shakings				
Progressive Memory Loss				
Kidney or Bladder Problems				
Do you have constant pain, pins and needles in your body? If yes, indicate which part/s		Specify which part/s		
Were you diagnosed with HIV?		Prefer not to disclose		
Previous operation/s?				
Possible future operation/s?				
Do you use a wheelchair or walking aid?				
Do you suffer from any other illness/es not mentioned above?		Specify		

Member signature

Date 

Y	Y	Y	Y	M	M	D	D
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