Nombre del alumno: Yoana Itzel Gutiérrez Álvarez

Nombre del profesor: Jezabel Ivonne Silvestre Montejo

Licenciatura: Lic. En enfermería 3er cuatrimestre

Materia: Ingles III

Nombre del trabajo: Ensayo

Ensayo del tema:

“Medical history form”

Frontera Comalapa, Chiapas a 15 de junio del 2020

MEDICAL HISTORY FORM

Please complete the following details for yourself as the main applicant/member

Title: **(Mr.)**

First name: **Tony**

Surname: **Santos**

Address: **Palms Avenue in Ohio, USA. He is from Tlaxcala, Mexico**

Postcode: **Post code 1800**

Sex at birth: ■ **Male** ☐ **Female**

Date of birth: **21 / 10/ 1985**

Membership number: **120098544722**

ADDITIONAL MEMBER DETAILS

Please give details of additional members you wish to be covered

Title, surname, first name(s)	**Relationship to you (Partner, dependant)**	**Date of birth Day Month Year**	**Sex at birth**
1. Mr. Tony Santos	dependent	21/10/1985	■ Male ☐ Female
2. Sra.Claire Benson	dependent	2/02/1990	☐ Male ■ Female
3. Noah Santos Benson	dependent	21/ 06/2015	■ Male ☐ Female
4. Peter Santos Benson	dependent	14/10/2017	■ Male ☐ Female

Your medical history

For any of the medical conditions or symptoms listed in questions 1 to please indicate if:

- ☐ You or anyone to be covered on your membership has seen a GP or other health care professional with in the last two years

- ☐ You or anyone to be covered on your membership has been admitted to hospital, had an operation OR any investigations (for example scan, X-ray, blood test, biopsy) within the last seven years.

1. Heart or cardiovascular disorders
eg coronary artery disease, chest pains, circulation problems, varicose veins, high blood pressure, venous ulcers

2. Glandular disorders
eg diabetes, thyroid, hormonal problems

3. Breathing or respiratory disorders
eg asthma, bronchitis, shortness of breath, chest infections, colds, flu

4. Ears, nose, throat, or eye problems **eg hayfever, tonsillitis, sinusitis, cataracts, eye infections, deafness, ear infections**

	Name		Name main Applicant		Name dependent Member 2		Name dependent member 3		Name dependent member 4		Name dependant member 5	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	■	□	■	□	□	□	□	□	□	□	□	□
2	■	□	■	□	■	□	□	□	□	□	□	□
3	■	□	■	□	□	□	■	□	□	□	□	□
4	■	□	■	□	□	□	□	□	■	□	□	□