MEGA INTERNATIONAL Health Care

Cardiovascular System Questionnaire

Name of proposed insured: ______________________________ Date of Birth: ______________________

Medical /Health Condition concerned: ____

Please tick the appropriate boxes and bracket when answering the below questions.

1. Description of signs and symptoms

(a) What were the chief complaints of the condition?

____

(b) When did you first become aware of the signs and symptoms?

____

(c) When did you first consult doctor to this condition?

____

(d) What was the diagnosis after investigation?

____

2. (a)Have you ever been told, advised of abnormal blood pressure readings by medical practitioner?
( ) No ( ) Yes. If “Yes”, please specify the name of condition (e.g hypertension, hypotension etc)

____

(b) What were the blood pressure readings when first consulted with doctor?

____

(c) Is there any underlying cause? ( ) No ( ) Yes. If “Yes”, please give details of the causes.

____

(d) Do you have any complications or other medical conditions diagnosed? ( ) No ( ) Yes.
If “Yes”, please give details of the complications.

____

(e) Have you smoke cigarettes with the last 12 months? ( ) No ( ) Yes. Please advise:
(i) average number of cigarettes daily ____
(ii) for how many years have you smoked ____

3. Please give a range of recent/current blood pressure readings including the most recent one with dates of taking such readings.

____

4. (a) When and what treatment was given to control the blood pressure?

____

(b) Are you currently taking any medication? If “yes”, please give details

____

5. Please give the dates and copy of results of any electrocardiogram, chest x-ray or other test that have been carried out.

____

6. Have you ever had abnormal cholesterol or lipid profile been tested? ( ) No ( ) Yes.
Please advise the findings and dates of test(s) done and copy of the laboratory reports.

____

7. (a) When and what treatment was given to control the cholesterol level?

____

(b) Are you currently taking any medication?   If "yes", please give details.
____

8. Have you ever been treated for, sought advice on, or had symptoms relating to chest pain, palpitation, heart problem or abnormality? ( ) No ( ) Yes , please give details.
____

9. Diagnostic procedure for the concerned medical condition stated above.
(Please attach copy of reports together with this questionnaire.)
( ) X-ray ( ) ultrasound ( ) MRI ( ) Biopsy ( ) Others – please specify
Findings of the report(s): ____

10. Diagnosis (as certified by the attending physician)
____
Complications (if any) ____

11. Treatment (Please tick the appropriate box and specify period of treatment with commencement and completion date.
( ) Oral medication – please provide details of medication _____________________________________
( ) Name & Date of Surgery (if done or planned to do) _____________________________________

12. Loss of time from work (please provide the duration and dates)
____

13. Are you currently received any treatment? ( ) No ( ) Yes. If "yes", please give details of treatment
____

14. Is regular follow-up required? ( ) No ( ) Yes. If answered "Yes",
( ) Any subsequent operation is required , please specify_____________________________________
( ) Any regular follow up or treatment is required, please specify
____
Date of latest follow up _______________________ Date of next follow up __________________

15. Any planned treatment or surgery is required? ( ) No ( ) Yes. If "yes", please give details of treatment.
____

16. Name and address of current attending doctor and hospital for treatment.
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I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true.

________________________________ ____________________
Signature of the proposed insured Date