Additional Medical Questionnaire

Name: _____ Date of Birth: _____

(Please tick the appropriate brackets when answering the below questions)

1. Do you smoke? (○) No (○) Yes, _____ years, _____ cigarettes per day

2. Have you ever been tested for Cholesterol or Triglycerides level?

   (○) No (○) Yes – please complete the following table and attach copy of the test results

Date of Test	Result			
	Total Cholesterol	HDL Cholesterol	LDL Cholesterol	Triglyceride

3. Treatment **(Please tick the appropriate brackets and specify period of treatment with commencement and completion date)**
   (☐) Medication – please provide details of medication with dosage _____
   (☐) Surgery / procedure – please specify _____

4. Have you ever been treated for, sought advice on, or had symptoms relating to chest pain, palpitation, heart problem or abnormality?

   (○) No (○) Yes – please provide details _____

5. Diagnostic procedure **(Please attach copy of the reports)**
   (☐) X-ray (☐) Ultrasound (☐) MRI (☐) CT (☐) ECG (☐) Treadmill (☐) Cardiogram (☐) Blood Test
   (☐) Others – please specify _____

   Findings of the above investigations: _____

6. Final Diagnosis _____

   Did any complication occur? (○) No (○) Yes – please provide details _____

7. Have you ever been advised of abnormal blood pressure readings by medical practitioner?

   (○) No (○) Yes – please specify the condition (e.g. hypertension, hypotension etc.) _____

   (a) What were the latest three doctor's follow up blood pressure readings? Please provide the readings and dates:

Date of Follow up	Blood Pressure Reading

   (b) When and what treatment was given to control the blood pressure?
   (☐) Medication – please provide details of medication with dosage _____
   (☐) Surgery / procedure – please specify _____

8. Have you ever been tested for fasting blood sugar or HbA1c?

   (○) No (○) Yes – please advise most recent results:

Date of Test	Fasting Blood Sugar Result	HbA1c Result

Please attach copy of the blood test results

9. Are you currently receiving any treatment such as medication, physiotherapy or Chinese medicine treatment etc.?

   (○) No (○) Yes – please provide details of treatment _____

10. Is regular follow-up required? (○) No (○) Yes

    Date of latest follow up _____ Date of next follow up _____

11. Is any planned treatment or surgery required?

    (○) No (○) Yes – please provide details _____

12. Name and address of recent attending doctor, and hospital for treatment of the above condition.

    _____

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