CARDIOVASCULAR AND CEREBROVASCULAR / NERVOUS SYSTEM QUESTIONNAIRE

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PROHealth

Important Notice
Statement pursuant to Section 25(5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application Form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed. Otherwise, the Policy issued hereunder may be void. Neither this Application Form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specific terms, conditions and exclusions applicable to this insurance are set out in the Policy, a copy of which is available upon request.

Please fill in ENTIRE FORM using BLOCK CAPITALS

Medical/health condition concerned: ______________________________

Name of Insured Person: ______________________________

ID/Passport Number: ______________________________

1. Please state the precise diagnosis of your cerebro/cardiovascular or nervous system problem, if known.

____

2. When was this condition first diagnosed?

____

3. Have you had any tests or other investigations for this condition? ☐Yes ☐No. If Yes, please provide details, including dates of investigations and results. (Please attach copy of medical report(s) with this questionnaire if available.)

____

4. Regarding your symptoms :
   a) Please describe your symptoms. ______________________________
   b) How frequently did the symptoms occur in the last 12 months? ______________________________
   c) Are you aware of any specific provoking cause(s) which trigger your symptoms? (e.g. exercise, stress.) ☐Yes ☐No. If Yes, please provide details.

   ____

   ____

   d) Do your symptoms restrict your activities in any way? ☐Yes ☐No. If Yes, please provide details.

   ____

   e) When was the last occurrence of the symptoms?

   ____

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage.
   a) Currently: ______________________________
   b) In the past: ______________________________
   c) How often do you need to obtain/purchase regular medication? ______________________________
   d) Chinese medicine practitioner or others: ______________________________
6. Regarding the monitoring of your condition:
   Name & address of your current treating Physician and/or Hospital: ______________________________

   ____

   a) How often do you attend follow-up? ______________________________
   b) When was your last consultation? ______________________________
   c) When is your next consultation? ______________________________
7. Do you currently smoke? ☐Yes ☐No. If Yes, how many cigarettes per day? ______________________________
8. Have you lost any time from work? ☐Yes ☐No. If Yes, please provide duration and dates. ______________________________
9. Please tell us your blood pressure: Highest ____________ Lowest ____________ Average ____________

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are complete and true.

______________________________ ______________________________

Signature of the Insured Person
(Signature by Policyholder if the Insured Person is a Minor)

Date

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