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Description automatically generated with medium confidence**HYPERTENSION QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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| **First Name:** |  | | **Last Name:** |  | |
| **Date of Birth** (mm/dd/yyyy): | |  | **Policy/Application No.:** | |  |

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| 1. When was your hypertension first diagnosed? | | | | | | | | | |
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| 1.1 Is this essential hypertension or is it due to another medical condition? (Note: Essential hypertension is high blood pressure that does not have a known secondary cause. It is also referred to as primary hypertension) | | | | | | | | | |
| Yes, it is essential hypertension. | | | | | No (Please give details.) | | | | |
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| 1. What was your most recent blood pressure reading within the last six (6) months? | | | | | | | | | |
|  | | | | | | | | | |
| 1. Are you currently on medication for hypertension? | | | | | | | | | |
| Yes (Please provide details in the table below and answer question no. 3.1.) | | | | | | | | | |
| No (Please provide reason/s why you are not currently on medication for your hypertension, and proceed to question no. 4.) | | | | | | | | | |
|  | | | | | | | | | |
| Name of Medication | Date Prescribed | | | Frequency and Dosage | | Date Medication Stopped | | | Reason |
|  |  | | |  | |  | | |  |
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|  |  | | |  | |  | | |  |
| 3.1 Has your medication for hypertension been increased by your attending physician in the past 6 months? | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | |
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| 1. Have you been hospitalized or had emergency care due to your hypertension in the past three (3 )years? | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | |
| Date of Confinement | | Treatment Received | | | | | Name of Hospital | | |
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| 1. Other than for the purpose of regular check-ups, has any further treatment, investigation or follow-up been discussed, recommended, or otherwise contemplated in relation to this condition? | | | | | | | | | |
| Yes (Please provide details.)  No | | | | | | | | | |
| Date | | Type of Diagnostic Test | | | | | Results | | |
|  | | ECG | | | | |  | | |
|  | | Chest X-ray | | | | |  | | |
|  | | Treadmill Stress Test | | | | |  | | |
|  | | 2D Echo | | | | |  | | |
|  | | 24-Hour Holter Monitoring | | | | |  | | |
|  | | Urinalysis | | | | |  | | |
|  | | Others | | | | |  | | |
| 1. How often has your treating doctor advised you to attend for review/check-up in relation to your hypertension? | | | | | | | | | |
|  | | | | | | | | | |
| 1. Have you ever had or do you currently have any of the following? | | | | | | | | | |
| Eye Disease | | | Yes  No | | | | | | |
| Kidney Disease | | | Yes  No | | | | | | |
| Proteinuria | | | Yes  No | | | | | | |
| Heart Disease | | | Yes  No | | | | | | |
| Stroke | | | Yes  No | | | | | | |
| Peripheral Vascular Disease | | | Yes  No | | | | | | |
| Diabetes Mellitus | | | Yes  No | | | | | | |
| Raised Cholesterol Level | | | Yes  No | | | | | | |
| 1. Please provide any additional information that you feel is important. | | | | | | | | | |
|  | | | | | | | | | |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition: | | | | | | | | | |
| Name of Doctor, Hospital or Clinic | | Address | | | | | | Date of Last Consultation (Month/Year) | |
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| **DECLARATION** |
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| **I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.**  **I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.** |

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| **Name:** |  |

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| --- | --- |
| **Signature:** |  |

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| **Date of Signing:** |  |

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