**HYPERTENSION QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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

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| --- |
| 1. When was your hypertension first diagnosed?
 |
|       |
| 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.) |
|       |
| 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 |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| 3.1 Has your medication for hypertension been increased by your attending physician in the past 6 months? |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 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 |
|       |       |       |
|       |       |       |
| 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.
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|       |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition:
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| Name of Doctor, Hospital or Clinic | Address | Date of Last Consultation (Month/Year) |
|       |       |       |
|       |       |       |

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| **DECLARATION** |
|  |
| **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.**  |

|  |  |
| --- | --- |
| **Name:** |       |

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

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| --- | --- |
| **Date of Signing:** |       |

