

Digestive System Diseases other than cancer

Disease: Please select from the below, the specific condition that applies to the insured

	Inflammatory Disease		Liver Disease
	Divericular Disease		Pancreatitis
	Gall Bladder Disease		

General Information

Last Name:		First Name:	
Date of Birth:		Age:	Sex:
Height : Cm		Weight: Kg	
Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many cigarettes per day? If No, did you ever smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>		For how many years? When did you stop?	
-Do you drink? If yes, what? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, how many drinks per day? If No, did you ever drink? Yes <input type="checkbox"/> No <input type="checkbox"/>	For How many years? When did you stop?
Name, address and telephone number of present attending Physician:			
Frequency of visits to physician:		Date of last visit: / /	
What is your disease? <input type="checkbox"/> Inflammatory <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Diverticular <input type="checkbox"/> Liver Disease			

Condition Profile

At what age were you told you had the disease?	
What were the first symptoms? <input type="checkbox"/> Bleeding <input type="checkbox"/> Diarrhea /Constipation <input type="checkbox"/> Icterus <input type="checkbox"/> Pain <input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Other: _____	
What test(s) have been done to diagnose your disease? <input type="checkbox"/> Gastroscopy Year..... <input type="checkbox"/> Colonoscopy Year..... <input type="checkbox"/> Ultrasound Year..... <input type="checkbox"/> CT Scan Year..... <input type="checkbox"/> Biposy Year..... <input type="checkbox"/> Other Year.....	Last Hemoglobin Reading and date: Date: __/__/____ Last Hematocrit Reading and date: Date: __/__/____
Have you ever had high Cholesterol level?What is your current Cholesterol level? <input type="checkbox"/> <200mg/dl <input type="checkbox"/> 200 mg/dl or more	Have you ever Had a transfusion? Yes <input type="checkbox"/> No <input type="checkbox"/> Quantity: _____ Date: __/__/____
Have you ever had high Triglyceride level?What is your current Triglyceride level? <input type="checkbox"/> <250 mg/dl <input type="checkbox"/> 250 mg/dl or more	
Treatment: <ul style="list-style-type: none"> • Diet: • Medication (Name and dosage): <ul style="list-style-type: none"> ○ . ○ . ○ . • Insulin • Surgery; If yes, when and what was the procedure • Have you ever been hospitalized for the disease? 	
Has treatment changed during the last five years? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe the change:	

Please continue filling in the next page

Digestive System Diseases other than cancer (cont'd)

Do you have Crohn's Disease or Ulcerative Colitis? Yes <input type="checkbox"/> No <input type="checkbox"/> . If Yes: How often do you have attacks? _____ Are the attacks becoming more frequent? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you on Steroids? Yes <input type="checkbox"/> No <input type="checkbox"/> For how long on Steroids? _____	Do you have a liver problem? Yes <input type="checkbox"/> No <input type="checkbox"/> . If Yes: AST/SGOT date: __/__/____ Result:____ ALT/SGPT date: __/__/____ Result:____ GGT date: __/__/____ Result:____ PT date: __/__/____ Result:____ Hepatitis A <input type="checkbox"/> , B <input type="checkbox"/> , C <input type="checkbox"/> , Other <input type="checkbox"/> _____
Please check the illnesses below that you have ever had:	
<input type="checkbox"/> Stroke Year..... <input type="checkbox"/> Heart Rhythm Problem Year..... <input type="checkbox"/> Liver Problem Year..... <input type="checkbox"/> Kidney Disease Year.....	<input type="checkbox"/> Edema Year..... <input type="checkbox"/> Eye trouble Year..... <input type="checkbox"/> Ulcer Disease Year..... <input type="checkbox"/> Other?..... Year.....
Do other members of your family have Hypertension? Yes <input type="checkbox"/> No <input type="checkbox"/> (if a parent is deceased, please list the cause of the death)	
If yes, who and what is the disease? - -	

Attending Physician:-----

Date -----/-----/-----

I hereby, give full and irrevocable authorization to the Insuranec Company, to the Administrator and to MedNet Delegates' (Physician and Nurses), to inquire about my actual state of health and that of my dependants from any Medical Center or Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company, the Administrator and MedNet Delegates'. Failure to disclose material information, whether by omission or false declaration, which the Insurance Company should have known, the latter will have the right to cancel my or my dependents' rights in coverage starting from the effective date of the policy without having any financial obligation.

Insured's Signature:-----

Date -----/-----/-----