

Respiratory Diseases other than cancer

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

<input type="checkbox"/>	<input type="checkbox"/>
Asthma	Interstitial Lung Diseases
<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary 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"/>	For how many years?
If yes, how many cigarettes per day?	When did you stop?
If No, did you ever smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name, address and telephone number of present attending Physician:	
Frequency of visits to physician:	Date of last visit: / /
What is your disease?	What is the severity of the Disease?
<input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Bronchitis	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
<input type="checkbox"/> Asthma <input type="checkbox"/> Restrictive Lung Disease	Coughing of Blood: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Coughing of Sputum: Yes <input type="checkbox"/> No <input type="checkbox"/>

Condition Profile

At what Age were you told you had a Respiratory Disease?	
Has a Pulmonary Test (Breathing test, Spirometry...) ever been done?:	
-Test Name:	Result: Date:
-Test Name:	Result: Date:
Treatment:	
❖ Medication (Name and dosage):	
1.	.
2.	.
3.	.
❖ Oxygenotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>
❖ Nebulizer	Yes <input type="checkbox"/> No <input type="checkbox"/>
❖ Inhaler	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you ever been hospitalized or got to the emergency room for this condition?	
Has treatment changed during the last five years? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, describe the change:	
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 Respiratory Disease? 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 -----/-----/-----