Endocrine Glands System Questionnaire

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

☐ Thyroid ☐ Adrenal Glands ☐ Metabolic Disorder ☐ Others _________
☐ Parathyroid ☐ Growth Disorder ☐ Pituatiry

General Information

Last Name: ________________________ First Name: ____________________ Occupation: ___________
Date of Birth: _______________________ Age: _______________________ Sex: _________________
Height: _____ Cm Weight: _____ Kg BMI: _________________

Name, address and telephone number of present attending physician: ____________________________________
____

Frequency of visits to physician: ☐ Occasionally ☐ Frequently
Date of last visit: ___ /___ /___

Do you smoke? ☐Yes ☐ No If Yes, how many cigarettes per day? ____________
For how many years? __________________________
Did you ever smoke? ☐Yes ☐ No If Yes, when did you stop? ______________________

Condition Profile

At what age were you told you had the disease mentioned above?_______________________________________

Did you ever have:			
	☐ Scintigraphy	Date: ___ /___ /___	Result: _______________
	☐ MRI	Date: ___ /___ /___	Result: _______________
	☐ Ultra Sound	Date: ___ /___ /___	Result: _______________
	☐ Blood Tests	Date: ___ /___ /___	Result: _______________
	☐ Other	Date: ___ /___ /___	Result: _______________

What is your Cholesterol level?	Date: ___ /___ /___	☐ <= 200mg/dl	☐ 200 mg/dl or more
What is your Triglyceride level?	Date: ___ /___ /___	☐ <= 250mg/dl	☐ 250 mg/dl or more
Result of last HbA1c:	Date: ___ /___ /___	☐ < 7%	☐ 7% or more

Treatment

☐ Diet
☐ Medication (Name and dosage):

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

☐ Surgery: ______________________________ Date: ___ /___ /___

Have you ever been hospitalized because of Diabetes? Yes ☐ No ☐
Has treatment changed during the last five years? Yes ☐ No ☐
If yes, describe the change ____

Please check the illnesses below that you have ever had:

☐ Stroke	…….. Year	☐ Kidney Disease	…….. Year
☐ Heart Peripheral Vascular Disease	…….. Year	☐ Eye trouble	…….. Year
☐ Nerve Disorder	…….. Year	☐ Other	…….. Year

Do other members of your family have Diabetes? Yes ☐ No ☐
Death of family members:
____
If yes, who and reason?
____

Attending Physician: ……………………………. Date: ___ /___ /___

I hereby declare that the above mentioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the policy contract, in favor of the Medical committees and doctors, requesting from them, and other insurance companies or any other guarantor which we had contracted with for medical and/or life insurance, to provide the insurance company and/or GlobeMed Lebanon with all the information and documents available at their side on our medical condition and of copies thereto, permitting GlobeMed Lebanon, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers, with all possible means, either through e-mail, or SMS or any other available mean.

Insured's Signature: ……………………………. Date: ___ /___ /___