Kidney Disease Questionnaire

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

☐ Glomerulonephritis ☐ Pyelonephritis ☐ Other _____

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: ___ /___ /___

What are the most recent laboratory test performed and their results?

- Blood Urea Nitrogen (BUN) : Date ___ /___ /___ Result: _____
- Creatinine: Date ___ /___ /___ Result: _____
- 24 hour Creatinine Clearance: Date ___ /___ /___ Result: _____
- 24 hour Protein Loss: Date ___ /___ /___ Result: _____
- Urinalysis Protein Loss Date ___ /___ /___ Result: _____

What where the first symptoms? _____

Did you ever have kidney failure? Yes ☐ No ☐
Was/is there blood in your urine? Yes ☐ No ☐
Did you ever have kidney stones? Yes ☐ No ☐
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

Have you ever been hospitalized for this condition? Yes ☐ No ☐
How many times? _____

- Medication (Name and dosage):

1. _____ 3. _____
2. _____ 4. _____

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 Yes ☐ No ☐
- Heart Rhythm Problem Yes ☐ No ☐
- Edema Yes ☐ No ☐
- Respiratory Disease Yes ☐ No ☐
- Liver Problem Yes ☐ No ☐
- Eye trouble Yes ☐ No ☐
- Diabetes Yes ☐ No ☐
- High Cholesterol level Yes ☐ No ☐
- Any other complications? Yes ☐ No ☐ _____

Do other members of your family have Respiratory Disease? Yes ☐ No ☐
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: ___ /___ /___