Arthritis Disease and Connective Tissue Disease Questionnaire

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

☐ SLE ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Juvenile Arthritis ☐ 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

What type of Arthritis do you have?

Date of last visit: …../….. /……

Are you able to work ☐Yes☐ No

Are you able to take care of yourself? ☐Yes☐ No

Body Area Affected: ………………………………..

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 been hospitalized for this condition? ☐Yes ☐ No, how many times? …………………………………

Did you go to the ER? ☐Yes ☐ No, how many times? ………………………

Treatment:

- Medication (Name and dosage):

	Medication	Continuously	As needed
1.	……………………………………………	☐	☐
2.	……………………………………………..	☐	☐
3.	……………………………………………..	☐	☐
4.	……………………………………………	☐	☐

5. Surgery: ☐Yes ☐ No, If yes, please describe:
………
………

Has treatment changed during the last five years? Yes ☐ No ☐

If yes, describe the change: ……………………………………………………………………………………………
……

Have you ever had (give dates, names, addresses and telephone numbers of Attending Physician):

Condition	Yes	No	Condition	Yes	No
Stroke	☐	☐	Eye trouble	☐	☐
Heart Rhythm Problem	☐	☐	Diabetes	☐	☐
Liver Problem	☐	☐	High Cholesterol level	☐	☐
Kidney Disease	☐	☐	Ulcer Disease?	☐	☐
Edema	☐	☐	Colon Problem	☐	☐
Skin Diseases	☐	☐	Any Other Complication? ……	☐	☐

Do other members of your family have Arthritic Disease? Yes ☐ No ☐

If yes, who and what is the Disease? ……………………………………………………………………………………
………

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: ………/………/………