Cardiovascular Disease Questionnaire

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

☐ Hypertension ☐ Valvular Diseases & Cardiomyopathy ☐ Coronary & Vascular Diseases
☐Other _________________ ☐ Arrhythmias & Conduction

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 Heart Disease? ____

Frequency of Blood Pressure Assessment: Date & Result of last Blood Pressure Assessment:
☐Daily ☐ Weekly ☐ Other ………….. Systolic: ………… Diastolic: ………. Visit date: ___ /___ /___

Have you ever had high Cholesterol level? What is your current Cholesterol level? ☐ <=200mg/dl ☐ 200 mg/dl or more
Have you ever had diabetes? What is your current Glucose level? ☐ <=110mg/dl ☐ 110 mg/dl or more ☐ HbA1c

Treatment

- Diet:
- Medication (Name and dosage):
  1. ______________________
  2. ______________________
  3. ______________________

Did you have a Heart Procedure, surgery or otherwise? ☐Yes ☐ No
If yes, when and Describe the Procedure: ____

Have you ever been hospitalized for this disease? ☐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 ☐ Edema …….. Year] Ulcer Disease …….. Year
☐ Heart Rhythm Problem …….. Year ☐ Eye trouble …….. Year] Other …….. Year
☐ Liver Problem …….. Year ☐ Kidney Disease …….. Year

Do other members of your family have disease? Yes ☐ No ☐
If yes, who and what is the type? ……………………………………………………………………………….

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: ___ /___ /___