Medical Conditions Questionnaire (to be completed by the member)

Member Full Name……Date of birth……

Policy number or scheme name……

Please complete the appropriate section(s) only after completing the Member's Declaration.

You must answer the questions fully and truthfully to the best of your knowledge. If you do not do so, and this affects our assessment of the risk, your insurance cover may be invalidated and this may result in your claim not being paid or not fully paid. If you are in any doubt about whether to provide information when filling in this form, please provide the information. If there is insufficient space please continue your answer in the section marked additional information on page 14.

If you suffer, or have suffered at any time, from any of the conditions listed below please complete the corresponding section of the questionnaire. Once you have completed the relevant sections please sign the declaration found on page 14.

Abnormal Smears	1	Heart Murmurs / Structural Defect / Irregular Heartbeat	10
Anxiety / Depression	2	High Blood Pressure	11
Arthritis	3	High Cholesterol	12
Asthma / Bronchitis	4	Hysterectomy	13
Back Trouble	5	Multiple Sclerosis	14
Chest Pain / Heart Disease	6	Renal / Urinary Tract Disorders	15
Diabetes	7	Stomach / Bowel Disorders	16
Epilepsy	8	Stroke / T.I.A	17
Growths, Cysts, Lumps & Tumours	9		

Section 1: Abnormal Smears

1 a) Have you ever had an abnormal smear? YES / NO
If yes, please advise date, diagnosis (if known) and any treatment given.

1 b) Have you subsequently had normal smears? YES / NO
If yes, please provide the dates of these smears.

1 c) Are you still having follow ups? YES / NO
If yes, please advise the frequency and by whom.
If no, please advise the date of the last follow up.

Section 2: Anxiety / Depression

2 a) Please advise the date you first consulted a doctor about this.
2 b) Please advise the diagnosis given.
2 c) Please advise the number and dates of any attacks / episodes you have had since then.
2 d) Have you ever had absence from work due to this complaint? YES / NO If yes, please advise the date and duration of any absences.
2 e) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
2 f) Please advise the name and dosage of any medication you are currently taking.
2 g) Please advise the date of your next follow up.
2 h) Have you been treated as a hospital out-patient? YES / NO If yes, please advise the date and hospital.
2 i) Have you been treated as a hospital in-patient? YES / NO If yes, please advise the date, length of stay, any treatment given and hospital.
2 j) Did any particular factor trigger your anxiety or depression? YES / NO If yes, please provide details.
2 k) Have you ever attempted to commit suicide? YES / NO If yes, please provide brief details and the date.

Section 3: Arthritis

3 a) Please advise what form of arthritis you have e.g. Rheumatoid Arthritis, Osteoarthritis.

3 b) Please advise date of first diagnosis.
3 c) Please advise which joints are affected, whether your movement is restricted and if so by how much.
3 d) Please advise the extent of your disability.
3 e) Have you ever been advised to have an operation? YES / NO If yes, please provide full details and dates.
3 f) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
3 g) Please advise the name and dosage of any medication you are currently taking.
3 h) Do you have regular follow-ups? YES / NO If yes, please advise the frequency, location and whom you see.

Section 4: Asthma / Bronchitis

4 a) Please advise date of first diagnosis.
4 b) Please advise the number of attacks per annum (on average). Please advise the date of the last acute attack requiring a consultation with a doctor.
4 c) Does asthma restrict or interfere with your daily activities in any way? YES / NO If yes, please provide details.
4 d) Please advise which circumstances bring on an attack e.g. stress, exercise, allergy.
4 e) Do you use a peak flow meter? YES / NO If yes, please provide the highest and lowest readings in the last 3 months.

4 f) Do you have nocturnal symptoms? YES / NO If yes, please advise the frequency per week.
4 g) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
4 h) Please advise the name and dosage of any medication you are currently taking.
4 i) Have you ever taken oral steroids for your asthma? YES / NO If yes, please provide dates for this.
4 j) Do you have regular check-ups? YES / NO If yes, please advise the frequency and whom you see.
4 k) Have you ever had to be admitted to hospital? YES / NO If yes, please advise the date and whether it was an emergency admission.
4 l) Have you had absences from work due to your asthma or bronchitis? YES / NO If yes, please provide the dates and duration of any absence.

Section 5: Back Trouble

5 a) Please provide full details of the precise diagnosis if known.
5 b) Please advise if you had absence from work or if it has affected your lifestyle. Please provide full details including dates and duration.
5 c) Please provide details of any treatment – either current or previous – including names of medication, dosage, physiotherapy etc.
5 d) Please advise if you are due to have surgery – please provide dates and type of surgery.
5 e) Do you still have symptoms? YES / NO If no, please advise the last time you had symptoms.

Section 6: Chest Pain / Heart Disease

6 a) Please advise the type of symptoms, date of their first occurrence and their duration.
6 b) Please advise what investigations were carried out and the results.
6 c) Please confirm the exact diagnosis.
6 d) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
6 e) Please advise the name and dosage of any medication you are currently taking.
6 f) Please advise if you have had or are due to have surgery – if yes, please provide dates and type of surgery.
6 g) Do you have regular follow-ups? YES / NO If yes, please advise the frequency, location and whom you see.
6 h) Please provide the date of the most recent attack / symptoms. Do you have any current symptoms? YES / NO If yes, please provide full details.

Section 7: Diabetes

7 a) Please advise date of first diagnosis.
7 b) Please advise name & address of doctor / clinic where you are treated.
7 c) Do you follow a strict diet? Please confirm how your diabetes is treated? Diet only YES / NO Diet & tablets YES / NO Please confirm which tablets are taken Diet & Insulin YES / NO Dosage : AM units PM Units Insulin only YES / NO Dosage : AM units PM Units

7 d) Please provide full details if your treatment has been changed within the last 2 years.
7 e) Please advise your usual test results for the following: Blood Glucose: below 8 / 8.1 to 9 / 9.1 to 11/ over 11 Urine Glucose: negative / Glucose + / Glucose++ /Glucose+++ or more
7 f) Please advise the date and result of your most recent HbA1C glycosylated haemoglobin.
7 g) Have you ever had a diabetic coma since your treatment commenced? YES / NO If yes, please provide full details including dates.
7 h) Have you, either currently or previously, suffered from any disease of the heart or circulation, eyes, blood pressure, kidneys (e.g. protein or albumin in urine) or nervous system (e.g. numbness / tingling)? YES / NO If yes, please provide full details.
7 i) Please advise if you had absence from work due to this complaint. Please provide full details including dates and duration.

Section 8: Epilepsy

8 a) Please advise date of first diagnosis.
8 b) Have you had a scan or any other tests? YES / NO If yes, please provide full details of the results.
8 c) Please advise if anything seems to bring on an attack.
8 d) Please advise type of attack : Absences (petit mal) / Fits (grand mal)
8 e) Please advise the frequency and duration of attacks and date of your last attack.
8 f) Have there been any episodes of status epilepticus? YES / NO If yes, please provide dates.

8 g) Please advise if you had absence from work due to this complaint. Please provide full details including dates and duration.
8 h) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
8 i) Please advise the name and dosage of any medication you are currently taking.
8 j) Do you have regular check-ups? YES / NO If yes, please advise the location and whom you see.

Section 9: Growths, Cysts, Lumps & Tumours

9 a) Please advise when it was first discovered.
9 b) Please advise what the symptoms were / are.
9 c) Please advise the location. Is it still there or has it been removed? If it has been removed please advise: **i.** Date of removal? **ii.** Who removed it (name of surgeon, G.P.)? **iii.** Where (which hospital)? **iv.** How (local anaesthetic, full operation, cryosurgery)? **v.** Any treatment subsequent to the removal (if medication – name and dosage, radiotherapy, chemotherapy)?
9 d) Were any investigations carried out? YES / NO If yes, please advise the results.
9 e) Please advise the exact medical diagnosis. Please advise if malignant or benign. If malignant please confirm the staging (e.g. TNM Classification)
9 f) Please advise the frequency and timescale of any follow ups. Do you still have regular follow-ups or any treatment? YES / NO If yes, please provide full details.

Section 10: Heart Murmurs / Structural Defect / Irregular Heartbeat

10 a) Please advise the type of symptoms, date of their first occurrence and their duration.
10 b) Please advise what investigations were carried out and the results.
10 c) Please confirm the exact diagnosis.
10 d) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
10 e) Please advise the name and dosage of any medication you are currently taking.
10 f) Please advise if you have had or are due to have surgery – please provide dates and type of surgery.
10 g) Do you have regular follow-ups? YES / NO If yes, please advise the frequency, location and whom you see.
10 h) Please provide the date of the most recent attack / symptoms. Do you have any current symptoms? YES / NO If yes, please provide full details.

Section 11: High Blood Pressure

11 a) Please advise date of first diagnosis.
11 b) Please advise how it was discovered / why your blood pressure was being checked at this time
11 c) Please advise what the reading was if known
11 d) Have you undergone investigations to ascertain the cause for this condition? YES / NO If yes, please advise the results of these investigations.
11 e) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.

11 f) Please advise the name and dosage of any medication you are currently taking.
11 g) Are you being treated for any other condition? YES / NO If yes, please confirm the condition and name and dosage of the medication.
11 h) Have your urine tests always been normal? YES / NO If no, please provide details.
11 i) Do you have regular checks? YES / NO If yes, please advise the location and whom you see.
11 j) Please advise your most recent blood pressure reading and the date it was taken.

Section 12: High Cholesterol

12 a) Please advise date of first diagnosis.
12 b) Please advise how it was discovered / why your cholesterol was being checked at this time
12 c) Please advise what the reading was if known.
12 d) Have you undergone investigations to ascertain the cause for this condition? YES / NO If yes, please advise the results of these investigations.
12 e) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
12 f) Please advise the name and dosage of any medication you are currently taking.
12 g) Are you being treated for any other condition? YES / NO If yes, please confirm the condition and name and dosage of the medication.
12 h) Do you have regular checks? YES / NO If yes, please advise the location and whom you see.
12 i) Please advise your most recent cholesterol reading and the date it was taken (this should include readings for total cholesterol, HDL, LDL and Triglycerides.

Section 13: Hysterectomy

13 a) Have you had a hysterectomy? YES / NO If yes, please advise the date and reason for the operation including if malignancy was suspected.
13 b) Please provide details of any follow up treatment.
13 c) Are you still having follow-ups? YES / NO If yes, please advise the frequency, date of most recent follow-up and by whom. If no, please confirm date of final follow-up

Section 14: Multiple Sclerosis

14 a) Please advise the type of symptoms, date of their first occurrence and their duration.
14 b) Have you undergone investigations to ascertain the cause for this condition? YES / NO If yes, please advise the results of these investigations.
14 c) Please advise the date you were diagnosed with Multiple Sclerosis.
14 d) Please advise the type of Multiple Sclerosis: Relapsing / Remitting / Progressive.
14 e) Please advise the date of your most recent symptoms.
14 f) Do you currently have symptoms? YES / NO If yes, do you have any of the following types of symptoms : Limping, mild sensory or visual disturbances. YES / NO Mild paralysis, occasional incontinence, mild thought disturbances YES / NO Is partial assistance or a walking cane require? YES / NO Is constant assistance required such as crutches or a wheelchair? YES / NO
14 g) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
14 h) Please advise the name and dosage of any medication you are currently taking.
14 i) Are you still having follow-ups? YES / NO If yes, please advise the frequency, date of most recent follow-up and by whom.

Section 15: Renal / Urinary Tract Disorders

15 a) Please advise the type of symptoms, date of their first occurrence and their duration.
15 b) Have you undergone any investigations e.g. blood tests, cystoscopy? YES / NO If yes, please provide full details including the date and results of these investigations.
15 c) Please confirm the exact diagnosis e.g. Kidney Stones, Cystitis, Prostatitis, Pyelonephritis and date of diagnosis.
15 d) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
15 e) Please advise the name and dosage of any medication you are currently taking.
15 f) Please advise if you have had or are due to have surgery – please provide dates and type of surgery.
15 g) If you have suffered this on more than one occasion please advise the dates and durations for each occurrence.
15 h) Are you still having follow-ups? YES / NO If yes, please advise the frequency, date of most recent follow-up and by whom. If no, please confirm date of final follow-up.
15 i) Please advise if you had absence from work due to this complaint. Please provide full details including dates and duration.

Section 16: Stomach / Bowel Disorders

16 a) Please advise the type of symptoms, date of their first occurrence and their duration.
16 b) Have you undergone any investigations? YES / NO If yes, please provide full details including the date and results of these investigations.

16 c) Please confirm the exact diagnosis e.g. Crohns Disease, Ulcerative Colitis, Hernia, Reflux
16 d) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
16 e) Please advise the name and dosage of any medication you are currently taking.
16 f) Please advise if you have had or are due to have surgery – please provide dates and type of surgery.
16 g) Have you had any problems since having surgery? YES / NO If yes, please provide full details.
16 h) Do you have any current symptoms? YES / NO If yes, please provide full details. Please confirm when was the last recurrence of this problem? Please confirm if you have made a full recovery. YES / NO
16 i) Are you still having follow-ups? YES / NO If yes, please advise the frequency, date of most recent follow-up and by whom. If no, please confirm date of final follow-up.
16 j) Please advise if you had absence from work due to this complaint. Please provide full details including dates and duration.

Section 17: Stroke / T.I.A (Transient Ischaemic Attack)

17 a) Please advise the type of symptoms, date of their first occurrence and their duration.
17 b) Have you undergone any investigations? YES / NO If yes, please provide full details including the date and results of these investigations.

17 c) Please confirm the exact diagnosis.
17 d) Please advise the name and dosage (if you remember them) of any medication you have previously been prescribed.
17 e) Please advise the name and dosage of any medication you are currently taking.
17 f) Please advise if you have had or are due to have surgery – please provide dates and type of surgery.
17 g) Are you still having follow-ups? YES / NO If yes, please advise the frequency, date of most recent follow-up and by whom. If no, please confirm date of final follow-up.
17 h) Please provide the date of the most recent attack / symptoms. Do you have any current symptoms? YES / NO If yes, please provide full details.

Additional Information:

I declare that the answers I have provided are truthful to the best of my knowledge, and that I have not withheld any information which may influence the acceptance of my cover. I understand that if any of the answers are later found to be untrue, inaccurate, or intended to mislead the insurers, they will be entitled to declare this insurance invalid and not pay claims or not fully pay claims.

I undertake to inform the insurers of any changes to the answers and information I have provided (after the declaration has been completed and up to the date it is accepted by the insurers).

Signed……..Date……

(Member)