

CEREBROVASCULAR & NERVOUS SYSTEM QUESTIONNAIRE

Please fill in ENTIRE FORM using BLOCK CAPITALS

(With reference to Q6i)

Medical/Health Condition concerned: _____

Name of Insured: _____

ID/Passport No.: _____

1. Please state the precise diagnosis of your cerebrovascular/nervous system problem, if known:

2. When was this condition first diagnosed?
_____3. Have you had any tests or other investigations for this condition? Yes No. If "Yes", please provide details, including dates of investigations and results (Please attach copy of medical report(s) with this questionnaire if available)

4. Regarding your symptoms :

a) Please describe your current symptoms, if any: _____

b) How frequently did the symptoms occur in the last 12-months? _____

c) Are you aware of any specific provoking cause(s) which trigger your symptoms? (e.g. exercise, stress). Yes No. If "Yes", please provide details _____d) Do your symptoms restrict your activities in any way? Yes No. If "Yes", please provide details: _____e) When was the last occurrence of the symptoms?

5. Please provide details of your treatment, including names of medication, dosage and frequency of dosage.

a) Currently: _____

b) In the Past: _____

c) How often do you need to obtain/purchase regular medication? _____

d) Chinese medicine practitioner or others: _____

6. Regarding the monitoring of your condition:

Name & address of your current treating Doctor and/or Hospital: _____

a) How often do you attend follow-up? _____

b) When was your last consultation? _____

c) When is your next consultation? _____

7. Do you currently smoke? Yes No. If "Yes", how many cigarettes per day _____

8. Loss of time from work (please provide duration and dates) _____

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true.

Signature of the Insured Individual / Main Applicant
(Signature by Policy owner if the Insured Individual is a Minor)_____
Date