PIONEER
YOUR INSURANCE

GlobalHealth®

GENERAL MEDICAL QUESTIONNAIRE

Please fill in ENTIRE FORM using BLOCK CAPITALS & tick the appropriate boxes when answering the questions.

Medical/Health Condition concerned: _____

Name of Insured: _____

Date of Birth (mm/dd/yyyy): _____

1. Within the last five years, has this person suffered from, been treated for, sought advice, or had symptoms relating diabetes, thyroid disorders or any other endocrine disorders?

☐ No ☐ Yes. **Please circle the condition as stated above.**

2. Description of symptom/s
   (a) When did the symptom/s occur? _____
   (b) Signs or symptom/s of the condition _____
   (c) Frequency & Duration of symptom/s occured _____
   (d) Time or Date of (i) Initial (first) episode _____
   (ii) Latest occurence _____

3. Diagnostic procedure (Please attach copy of the report together with this questionnaire.)

☐ X-ray ☐ Ultrasound ☐ MRI ☐ Biopsy ☐ Others - please specify

Findings of the investigation/s above: _____

4. Final Diagnosis _____
   (If it is caused by accident, please provide details)
   Any complication occured? ☐ Yes ☐ No
   If "yes", please give details of treatment _____

5. Treatment (Please tick the appropriate box and specify period of treatment with commencement and completion date.
   ☐ Oral medication - please provide details of medication _____
   ☐ Name & Date of Surgery _____

6. Loss of time from work (please provide the duration and dates)

_____

7. Do you currenctly receive any treatment?

☐ No ☐ Yes, please give details _____

8. Is regurlar follow-up or screening of endoscopy required? ☐ Yes ☐ No
   If answered "Yes", _____
   Date of latest follow up _____ Date of next follow up _____

9. Any planned treatment or surgery required?
   If "Yes", please give details of treatment _____

10. Name and address of currenct attending doctor and hospital for treatment.

_____

11. Are you fully recovered? ☐ Yes ☐ No

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

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