

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS**

Medical/health condition concerned: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

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 symptoms. \_\_\_\_\_
  - 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 Physician 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. Have you lost any time from work?  Yes  No. If Yes, 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 Person  
(Signature by Policyholder if the Insured Person is a Minor)

\_\_\_\_\_  
Date