

HEALTH QUESTIONNAIRE



A. MEDICAL HISTORY OF THE APPLICANT AND THE DEPENDANTS

Have you or any of your dependants ever experienced any of the following conditions, if you have answered "YES" to any of the questions, please provide us with full details for that person in the space provided. If you or any of your dependants suffer from a chronic condition, please provide us with the medical report from your treating doctor stating particulars of the condition and the duration and the estimated cost of treatment per annum.

1. In the last 12 months, have you or any of your dependants ever had medical problems or received treatment relating to:

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| 1.1. Physical disability since birth. | YES | NO |
| 1.2. Disorders of the heart and blood vessels. (e.g. hypertension, heart attack, heart failure, vascular disease) | YES | NO |
| 1.3. Disorders of the skin. (e.g. psoriasis, acne, cancer, eczema, allergies.) | YES | NO |
| 1.4. Disorders of the muscles, joints, and spine. (e.g. rheumatism, osteo or rheumatoid arthritis, muscular dystrophy) | YES | NO |
| 1.5. Disorders of the special senses: vision, touch, hearing, taste and smell. (e.g. blindness, cataracts, glaucoma, and deafness.) | YES | NO |
| 1.6. Disorders of the respiratory tract or lungs. (e.g. asthma, bronchitis, tuberculosis, persistent cough, emphysema.) | YES | NO |
| 1.7. Disorders of the digestive system, gallbladder or liver. (e.g. gastric, duodenal ulcers, recurrent heartburn, gallstones, liver cirrhosis, hepatitis B, spastic colon, Crohns disease, pancreatitis, Irritable Brown syndrome.) | YES | NO |
| 1.8. Disorders of the bladder, kidney and reproductive system. (e.g. kidney stones, infertility, recurrent bladder infections, ovarian cysts, endometriosis, erectile dysfunction, prostatitis) | YES | NO |
| 1.9. Disorders of the hormonal and endocrine system. (e.g. post menopausal syndrome on HRT, diabetes, hypo and hyperthyroidism.) | YES | NO |
| 1.10. Disorders of the nervous system or mental illness. (e.g. epilepsy, paralysis, speech disorder, depression, anxiety, bipolar mood disorder, schizophrenia, Alzheimer's, Parkinson's disease, chronic headaches or migraines) | YES | NO |
| 1.11. Disorders of the immune system. (e.g. scleroderma, psoriasis, HIV/AIDS, systemic Lupus Erythematosus) | YES | NO |
| 1.12. Disorders of the ear nose and throat. (e.g. hay fever, allergic sinusitis, tonsillitis, ear infections) | | |
| 1.13. Substance dependence. (e.g. alcohol, drugs, sleeping tablets, painkillers) | YES | NO |
| 1.14. Special dental treatment. (e.g. root canal treatment, crowns, orthodontics.) | YES | NO |
| 1.15. Metabolic disorders. (e.g. obesity, porphyria, gout) | YES | NO |
| 1.16. A disease or medical condition for which you or any of your dependants are receiving a payment and / or guaranteed medical treatment of whatever nature. (e.g. disability pensions, hospital plans) | YES | NO |
| 1.17. In the last 12 months, have you or any of your dependants been hospitalized for any reason. (e.g. surgery, accident, medical investigations.) | YES | NO |
| 1.18. Are you or any of your dependants currently receiving ongoing treatment for any disorder? (e.g. depression, epilepsy, diabetes, asthma, hypertension, cancer.) | YES | NO |
| 1.19. For female applicants and female dependants. Do you suspect that you are pregnant, if so how many months? | YES | NO |

