

## Medical Questionnaire: Eyes, Ears & Speech-related Conditions

NRIC of Life Assured: Please attach certified true copies of ALL the relevant laboratory evidences / tests available. Visual acuity test results ☐ Brainstem Auditory Evoked Response (BAER) report ☐ Laryngoscopy report Ophthalmologist report Pure Tone Audiometry test results Other reports. Please give details: □Yes Are you the Life Assured's usual medical attendant? □No (dd/mm/yyyy) If "YES", since what date? Has the Life Assured previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses? ☐ No Yes If "YES", please provide the following: Medical Condition Date of Medication / Treatment Name of Treating Doctor Name of Clinic/ Hospital Diagnosis and Address 3. Date when Life Assured FIRST consulted you for the illness. (dd/mm/yyyy) Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Life Assured had been experiencing these symptoms. Symptoms Date symptoms first started (dd/mm/yyyy) (a) (b) What is the source of this information? Patient Referring doctor Name of doctor and hospital / clinic : \_\_\_ Others, please specify: \_ Diagnosis Please describe the full and exact diagnosis. (i) (dd/mm/yyyy) Date when the illness was FIRST diagnosed (ii) (iii) Diagnosis was FIRST made by (name of doctor and hospital) (dd/mm/yyyy) (iv) Date when Life Assured FIRST became aware of the illness. 6. What is the underlying cause of the illness?

Name of Life Assured:



	When was the underlying cause FIRST diagnosed?	/ / (dd/mm/yyyy)  Name of treating doctor and clinic / hospital.
7.	Type of investigations / tests done to confirm the diagnosis.	
8.	Please give details of completed, planned or current treatment for the illness stated above.	
9.	What is the best corrected visual acuity of both eyes <u>at present</u> :	Date of test :
10.	Please complete the following:  (i) What is the best corrected hearing frequency of both ears at present:	(i) Date of test :
	<ul> <li>(ii) Was the above test done using a hearing aid?</li> <li>(iii) Can the hearing be improved with the use of a hearing aid?</li> <li>(iv) Has a hearing aid been recommended to the Life Assured?</li> <li>(v) If a hearing aid was not recommended, please give details as to why it was not recommended.</li> </ul>	(ii) No Yes (iii) No Yes (iv) No Yes (v)
	details as to why it was not recommended	
11.	Has the Life Assured previously suffered from any ear disease, exposure to noisy environment or any significant illness?	No Yes If "YES", please give full details including:  Diagnosis:  Date of onset:  Name of treating doctor and clinic / hospital:
12.	<ul> <li>(i) Does the Life Assured have any psychiatric disorders?</li> <li>(ii) Is the loss of speech related to the psychiatric disorder?</li> <li>(iii) What are the laryngoscopic findings?</li> </ul>	(i) No Yes (ii) No Yes If "YES" please give details (iii)
13.	When was the Life Assured FIRST diagnosed to have <u>early</u> loss of vision / hearing / speech?	/ / (dd/mm/yyyy)



14.	Is the Life Assured's vision / hearing / speech likely to improve with surgery or other therapy?	No
15.	Is the loss of vision / hearing / speech considered permanent and irreversible?	□ No □ Yes
	If "YES", please provide the date when loss of vision / hearing / speech was certified as total, permanent and irreversible:	/
16.	What is the prognosis of the Life Assured's loss of vision / hearing / speech?	Recovered Stable and improving Progressively worsening No change. Loss of vision / hearing / speech likely to be permanent and irreversible.
TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST		
Sign Date	ature and Official Stamp	me : dress :