Medical Questionnaire: HIV-related Conditions

Name of Life Assured :

NRIC of Life Assured :

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- ☐ HIV Antibody Test results
- ☐ Western Blot Test results
- ☐ Other HIV confirmatory test results
- ☐ CD4 Cell Count Test results over past 6-9 months
- ☐ Statement from the Hospital authority that the HIV infection was acquired from the tainted blood that was transfused in that Hospital
- ☐ All serial Full Blood Picture blood test results over past 6-9 months
- ☐ Histopathology examination (HPE)/ Biopsy report for Kaposi sarcoma or Malignant lymphoma
- ☐ CT Scan/ MRI of Brain for progressive multifocal leukoencephalopathy.

If Pneumocystic carinii pneumonia or tuberculosis:

- ☐ Chest X-ray report
- ☐ Sputum C & S report
- ☐ Sputum AFB
- ☐ Other reports. Please give details: _____

1. Are you the Life Assured's usual medical attendant? ☐ No ☐ Yes

   If "YES", since what date? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

2. 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 Diagnosis	Medication / Treatment	Name of Treating Doctor	Name of Clinic/ Hospital and Address

3. Date when Life Assured FIRST consulted you for the illness. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. 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 : _____

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5. Diagnosis (i) Please describe the full and exact diagnosis. (ii) Date when the illness was FIRST diagnosed (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iv) Date when Life Assured FIRST became aware of the illness.	(i) _____ _____ (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) (iii) _____ _____ (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
6. What is the underlying cause of the illness? 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. (i) How did the Life Assured contract HIV infection? (ii) How did the Life Assured become aware of the HIV positive status? (iii) When was the HIV infection FIRST diagnosed?	(i) _____ (ii) ☐ Incidental finding through blood test ☐ Symptomatic If symptomatic, please give details: Symptoms / Date of onset (a) / (b) / (c) (iii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Name of doctor and clinic / hospital. _____
10. Did the Life Assured give history of any of the following: (i) Homosexual behaviour (ii) Multiple sexual partners (iii) Intravenous drug user (iv) Haemophilia (v) Spouse with HIV infection	(i) ☐ No ☐ Yes (ii) ☐ No ☐ Yes (iii) ☐ No ☐ Yes (iv) ☐ No ☐ Yes (v) ☐ No ☐ Yes

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11.	(i)	If the HIV infection was contracted through blood transfusion, what was the reason for the blood transfusion?	(i) _____
	(ii)	Was the blood transfusion medically necessary or given as part of medical treatment?	(ii) ☐ No ☐ Yes
	(iii)	Was the blood transfusion received in Malaysia or Singapore?	(iii) ☐ No ☐ Yes
	(iv)	Please state the date of blood transfusion.	(iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
	(v)	Is the source of HIV infection established to be from the hospital that provided the blood transfusion?	(v) ☐ No ☐ Yes If "YES", please give the name and address of the hospital where the transfusion took place. _____
	(vi)	Is the institution able to trace the origin of the HIV tainted blood?	(vi) ☐ No ☐ Yes If "YES", please give details _____
	vii)	Is there any western blot test performed?	(vii) ☐ No ☐ Yes If "YES", please give details _____
12.	(i)	What is the latest CD4 cell count?	(i) Date : ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) CD4 cell count : _____
	(ii)	Did the Life Assured lose any weight over the past 6 months?	(ii) ☐ No ☐ Yes
	(iii)	If "YES", what is the weight loss?	(iii) _____ kg
	(iv)	Is there Kaposi sarcoma?	(iv) ☐ No ☐ Yes
	(v)	Is there Pneumocystitis Carinii Pneumonia?	(v) ☐ No ☐ Yes
	(vi)	Is there Progressive multifocal leukoencephalopathy?	(vi) ☐ No ☐ Yes
	(vii)	Is there active tuberculosis?	(vii) ☐ No ☐ Yes
	(viii)	Is there malignant lymphoma?	(viii) ☐ No ☐ Yes
	(ix)	What is the latest lymphocyte count?	(ix) Date : ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Lymphocyte count : _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

Signature and Official Stamp Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)	Name : _____ Address : _____ _____ _____

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