Medical Questionnaire: Lung-related Conditions

Name of Life Assured : _____

NRIC of Life Assured : _____

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

☐ Lung Function test results for the past 2 years
☐ Arterial Blood Gas test results for the past 2 years
☐ 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 : _____

5. Diagnosis

   (i) Please describe the full and exact diagnosis. (i) _____

   (ii) Date when the illness was FIRST diagnosed (ii) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)

   (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) _____

   (iv) Date when Life Assured FIRST became aware of the illness. (iv) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)

6. Type of investigations / tests done to confirm the diagnosis. _____

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7.		Please give details of completed, planned or current treatment for the illness stated above.	_____ _____ _____
8.	(i)	Does the Life Assured have dyspnea at rest?	(i) ☐ No ☐ Yes
	(ii)	Is Life Assured on continuous permanent oxygen therapy at present?	(ii) ☐ No ☐ Yes
	(iii)	How is the oxygen administered at home?	(iii) _____
	(iv)	Does the Life Assured have chronic respiratory failure?	(iv) ☐ No ☐ Yes
	(v)	Date chronic respiratory failure was diagnosed.	(v) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
9.	(i)	Is the respiratory failure due to asthma, COPD, chronic bronchitis, tuberculosis, pulmonary fibrosis, other lung disease or any other significant illness?	(i) ☐ No ☐ Yes If "YES", please give full details including: Diagnosis : _____ Date of onset : _____ Name of treating doctor and clinic / hospital : _____
	(ii)	When was the Life Assured FIRST diagnosed to have <u>early</u> lung disease?	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

10. Please provide details of the lung function tests done (including dates and results)

Lung Function Tests	Date: _____	Date: _____	Date: _____	Date: _____
FEV1				
FVC				
Others				

11. Please provide details of all arterial blood gas (ABG) analysis done (including dates and results)

Arterial Blood Gas Analysis	Date: _____	Date: _____	Date: _____	Date: _____
PaO_2				
$PaCO_2$				

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

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

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