UniversalHealth 100
MEDICAL INSURANCE PLAN
全健100醫療保險計劃

ZURICH®

CEREBROVASCULAR & NERVOUS SYSTEM QUESTIONNAIRE

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS** (With reference to Q6l)

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 current symptoms, if any: ______________________________

   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. Loss of time from work (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

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