

# MUSCULO-SKELETAL QUESTIONNAIRE

Please fill in **ENTIRE FORM** using **BLOCK CAPITALS**

(With reference to Q6K)

Medical/health condition concerned: \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_

ID/Passport No.: \_\_\_\_\_

1. Please state the precise diagnosis, 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. Did the test or investigation show any degenerative changes, fracture, prolapse or joint or vertebral or disc or any other musculo-skeletal problem?  Yes  No. (If "Yes", please provide details)

\_\_\_\_\_

5. Regarding your symptoms

a) Please describe your symptoms: \_\_\_\_\_

b) When did the symptoms first occur? \_\_\_\_\_

c) How frequently, in the last 12-months, did the symptoms occur? \_\_\_\_\_

d) When did you last have the symptoms? \_\_\_\_\_

e) Are your activities restricted in any way?  Yes  No. (If "Yes", please provide details)

\_\_\_\_\_

6. Have you had an operation/treatment for this condition or is an operation/treatment being considered?  Yes  No. (If "Yes", please provide date(s) and full details including names of hospital and consultant/surgeon)

\_\_\_\_\_

7. Please provide details of your treatment, including names of medication, dosage and frequency of dosage:

Name & address of your treating Physician and/or Hospital: \_\_\_\_\_

a) Currently: \_\_\_\_\_

b) In the past: \_\_\_\_\_

c) Chinese medicine practitioner or others: \_\_\_\_\_

8. Regarding the monitoring of your condition:

Name & address of your current treating Physician and/or Hospital (if different from 7 above): \_\_\_\_\_

\_\_\_\_\_

a) State your last follow-up date: \_\_\_\_\_ Next follow-up date: \_\_\_\_\_

b) If you have been discharged from follow-up, please state when: \_\_\_\_\_

9. Have you lost any time from work as a result of this condition? (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