

# CONFIDENTIAL MEDICAL HISTORY (MAXMEDICAL SHIELD)

## ❗ IMPORTANT NOTES:

- Please answer the questionnaire completely and accurately in BLOCK CAPITALS.
- Kindly disclose all known medical conditions or suspected conditions and symptoms, whether or not professional advice has already been sought.
- Further information, if required, will need to be provided.
- Failure to disclose all the material facts may result to termination of cover or non-payment of claims.

## 1. APPLICANT

First Name					
Surname					
Date of Birth (dd/mm/yyyy)		Height (cm)		Weight (kg)	

## 2. PLEASE ANSWER ALL QUESTIONS WITH A 'YES' OR 'NO' AND PROVIDE COMPLETE DETAILS IF THE ANSWER IS 'YES' (EXCEPT FOR QUESTION 1)

1. Are you in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has an application for a health policy made by you to this or any other insurer ever been withdrawn or dropped, deferred or declined, or accepted with an extra premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you smoke or consume tobacco? If yes, please state the quantity per day:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you drink alcohol? If yes, how many units of alcohol do you drink per week? (1 shot = 1 unit, 250ml beer = 1 unit, 1 glass of wine = 1 unit)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you wear any visual aids, glasses or contact lenses? If yes, please state for what condition:	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. (For females only) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you suffered any diseases/illnesses and seen a doctor or healthcare professional in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been absent from work due to illness or injury for a continuous period of more than 10 days during the last one year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you undergone any Inpatient stay in a hospital or nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you been taking any medications on a regular basis (e.g. pain killers, chronic medications, hormone treatment)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 3. PLEASE INDICATE IF YOU HAVE HAD COMPLAINTS REGARDING, SYMPTOMS OF, RECEIVED TREATMENT FOR, UNDERGONE TESTS OR INVESTIGATIONS, HAVE BEEN DIAGNOSED OR HOSPITALISED FOR:

11. Epilepsy, stroke, multiple sclerosis, migraine or any other neurological disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Anxiety, schizophrenia, depression, or any other psychological, psychiatric or mental illnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Arthritis, rheumatism, gout, osteoporosis, joint replacement, paralysis or any other skeletal and muscular disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Dermatitis, acne, psoriasis, eczema or any other other skin problems or allergic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Tumours, cancer, lumps, cysts, fibroids or any abnormal growth whether benign or malignant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Heart diseases, high/low blood pressure, heart failure, aneurysm, varicose veins or any other heart and circulatory disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Any disorders of the stomach, intestines, kidney, liver, bladder or any abdominal organ problem and endocrine disorders including diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Abnormal blood tests, anaemia, high cholesterol, malaria, Hepatitis B or C, HIV/AIDS or any other blood disorders and auto immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Pneumonia, bronchitis, asthma, tuberculosis and any other breathing or respiratory disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No

