

HYPERTENSION QUESTIONNAIRE

(To be completed by the medical attendant of the life to be assured or medical examiner)

Full name of life to be assured

Proposal number /Application number

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1. Current blood pressure measurement of the life to be assured.

Blood pressure 1st reading _____ 2nd reading _____ 3rd reading _____

Systolic _____

Diastolic (5th Phase) _____

2. a. Date / month and year when elevated blood pressure was first noticed.

b. State blood pressure readings at that time.

Systolic : _____

Diastolic : _____

3. a. Type of hypertension essential secondary

b. If secondary, indicate the cause.

ANSWER "YES" OR "NO" TO QUESTION 4 TO 6. IF "YES", GIVE DETAILS.

4. A. Is he/she under treatment for hypertension? Yes No

B. How long is he/she under medication?

C. Details of current treatment

5. Is he/she taking medicine for hypertension regularly? Yes No

6. How frequently is the blood pressure measured to assess the adequacy of control?

7. Has he/she been able to achieve a level of 130/80 or 120/80? Yes No

8. Is there any complaint suggestive of

a) Renal disease? Yes No

b) Visual defects? Yes No

c) Neurological symptoms? Yes No

d) Cardiovascular Disease? Yes No

e) Any other disease? Yes No

If yes, please give details.

Since when is the life to be assured completely free from symptoms?

9. If a regular blood pressure record has been maintained, please provide 4 representative readings done at intervals of 15 days or 1 month.

10. At the time of diagnosis: Were the following investigations done?

If yes give reports.

1. S. Creatinine Yes No

2. X Ray Chest Yes No

3. ECG Yes No

4. Eye examination for change in fundii Yes No

If yes, mention the reports with the dates

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I hereby agree that the forgoing questions and answers shall form part of the proposal for insurance made by me to the Compa

Place: _____

Date: _____

Signature of the Life to be Assured / Proposer

Signature of the Medical Examiner / Code No