

NAME		
FIRST NAME		
DATE OF BIRTH		APPLICATION OR POLICY NUMBER
D	M	Y

HYPERTENSION QUESTIONNAIRE

1. Date of the first diagnosis of high blood pressure: ____/____/____
D M Y

2. Please provide the blood pressure reading when diagnosed: _____

3. Since when are you under treatment? _____

4. Name and dosage of the prescribed medication(s): _____

5. Do you take your medication(s) on a regular basis? Yes No
 If no, provide the complete details: _____

6. Please provide the dates of, and your last 3 blood pressure readings:
 Date: ____/____/____ Blood Pressure Reading: _____
D M Y
 Date: ____/____/____ Blood Pressure Reading: _____
D M Y
 Date: ____/____/____ Blood Pressure Reading: _____
D M Y

7. Name and address of the attending physician: _____

8. Follow-up consultations: Every : 3 months 6 months Annually Other: _____
 Date of the last consultation: ____/____/____
D M Y

9. Have you ever had an electrocardiogram (ECG)? Yes No
 Date(s): ____/____/____ Result(s): _____
D M Y

10. Have you ever been hospitalized for high blood pressure: Yes No
 If yes, provide the date: ____/____/____ an location: _____
D M Y

11. Have you ever had any complications such as:
 Cerebrovascular Accident (CVA): _____
 Transient Ischemic Attack (TIA): _____
 Numbness: _____
 Paralysis: _____
 Kidney Disorder: _____

Please provide any additional important information: _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X _____ SIGNATURE OF THE PROPOSED INSURED	X _____ SIGNATURE OF THE POLICY OWNER
X _____ WITNESS	_____ DATE