RESOLUTION life

Boskruin Office Park,
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HYPERTENSION QUESTIONNAIRE (BY DOCTOR)

INDIVIDUAL POLICY ☐ CORPORATE SCHEME ☐

THIS QUESTIONNARE WILL FORM PART OF APPLICATION NO: _____ Date D D M M Y Y Y Y

ON THE LIFE OF: _____ ID No.

Contact Details Home No. (C O D E) Work No. (C O D E)

Fax No. (C O D E) Mobile No.

Email Address

Postal Address

Code C O D E

1. How long have you attended the applicant?

2. When did you first discover the applicant's blood pressure was above normal?

3. What were the blood pressure readings at that time? (Please give highest and lowest pre-treatment figures)

4. Were any funduscopic abnormalities noted? ☐ YES ☐ NO

   If "YES", please provide details

5. a) When was anti-hypertensive treatment instituted?

   b) What type of treatment was given? (e.g. diet, drugs, surgery or combination)

   If drugs were prescribed give details including dosage. (If different drugs were used at different periods, please indicate these particulars for each period and state reason for change.)

6. a) What effect did treatment have on the blood pressure?

   Please give representative readings.

   b) Is the applicant still on treatment? ☐ YES ☐ NO

   If "NO", when was treatment stopped?

7. What are the applicant's most recent blood pressure levels?

8. Please give date(s) and result(s) of any electro-cardiographic, radiological or other investigations which may have been carried out. (Original ECG tracings should be attached. These will be returned to you in due course.)

I hereby declare that the above particulars and answers are complete and true.

Signed at _____ this _____ day of _____ _____

Year of first qualifying: _____ Signature of Medical Attendant _____

SAMDC REGISTRATION NO:	
RAMS PRACTICE NO:	

Address

Code C O D E

Please note that in the event of any modification or variation of this standard form Resolution Life will regard this form as being invalid and of no force and effect.
Do not sign blank or incomplete forms.