Generic Medical Questionnaire

Date:_____

Name:_____ Date of Birth:_____

Address:_____ City:_____

Province:_____ Postal Code:_____ Phone Number:_____

Trip Information: Departure Date:_____ Return Date:_____

Insurance Option Plans: Single Trip ☐ 8 Day Annual ☐ 15 Day Annual ☐ 30 Day Annual ☐ Top Up ☐

****List all Medical Conditions, Medications, when diagnosed/prescribed and when the last change was.****

Medical Condition	**Yes**	**No**	**Number of Medications**	**Names of medications and date of last change**
Circulatory				
High Blood Pressure/ Hypertension				
High Cholesterol				
Circulatory Disorder of Artery or Vein (PVD, PAD, DVT)				
Blood disorder (Anemia and other)/Blood Clots				
Aneurysm of any type and size			What size of your aneurysm in mm? _____mm	
Other circulatory disorder not listed above				
Hospitalized for any circulatory disorder in the last 6 months			Date of hospitalization _____	
Cardiovascular/Heart				
Arrhythmia/Atrial Fibrillation/ Arteriosclerosis/ Heart Murmur				
Stent/ Pacemaker Implant/ Defibrillator				
Heart Attack (Myocardial infraction) Chest Pain/Angina				
Congestive Heart Failure/ Water on the lungs				
Last By-pass/ Valve surgery/ angioplasty within the last 12 years				Date of procedure_____
Last By-Pass/ Valve surgery/ angioplasty over 12 years ago				Date of procedure_____
Have you ever seen a Cardiologist/ Heart Specialist			When and Why? _____	

Other cardiac problems including congenital heat disorders				
Description of cardiac problems				
Hospitalized for any cardiac condition in the last 12 months			Date of hospitalization_____	
Cerebrovascular/Neurological				
Stroke (CVA/TIA) Cerebrovascular accident/ Transient ischemic attack (Mini Stroke				
Other Cerebrovascular / Neurological condition or disorders including Syncope, Alzheimer's, ALS, Parkinson's, MS, Cerebral Palsy				
Description of Cerebrovascular or Neurological conditions				
Hospitalized for any CV/N condition in the last 12 months			Date of hospitalization_____	
Respiratory/Lung				
COPD/ Emphysema/ Chronic Bronchitis				
Asthma				
Inhaler/Puffer – single unrepeated prescription for a single episode				
Have you ever been on Home Oxygen or prednisone				
Other lung disease or respiratory conditions				
Description of other respiratory conditions				
Hospitalized for any respiratory condition in the last 12 months			Date of hospitalization_____	
Gastro-Intestinal/Liver/Kidney Disorders & All Internal Disorders				
Stomach/bowel disorder or obstruction				
Diverticular Disorder				
Gastrointestinal Bleeding				
Bleeding or perforated ulcer				
Chronic Bowel Disorder (IBS)				
Liver Disorder/Spleen/Pancreas /Gall Bladder disorder, Gall stones not eliminated				
Cirrhosis of the liver				
Kidney Dialysis/ Renal Insufficiency				
Kidney disorder, Urinary disorder, kidney stones				

Other GIT or Internal condition including ulcer, hernia, acid reflux (GERD), or prostate disorder (Not Cancer)				
Description of gastrointestinal/ liver/kidney conditions				
Organ Transplant				
Hospitalized for any GIT or Internal Condition			Date of hospitalization_____	
Cancer				
Have you ever had cancer			What type:_____ When:_____	
What kind of treatment did you receive				
Diabetes				
Diabetes with insulin				
Diabetes with oral medication				
Diabetes without medication				
Hospitalization for diabetes within the last 6 months			Date of hospitalization:_____	
Other Risk Factors				
Have you smoked or used tobacco products within the last 2 years				
Have you been to the hospital/emergency room in the past 12 months?				
Have you seen a doctor in the last 12 months?				
Prescribed medication you have not listed in the above questionnaire				

I hereby confirm that the statements and answers given herein are accurate, true and complete. I declare to have read and understood the above questions, regarding my health issues. I understand that if pertinent medical information is omitted and/or falsified, the Insurance Company may reduce my coverage and or render my policy null and void.

Signature:_____ Date:_____