

American Life Insurance Company
Narayani Complex, Pulchowk,
P. O. Box: 11590, Kathmandu, Nepal,
Tel.: 5-555166, Fax: 5-555173

High blood pressure questionnaire – Applicant

Full Name: **Application/Policy No.:**

1. When was high blood pressure first diagnosed ?

2. Why was your blood pressure measured at that particular time ? eg routine examination, due to symptoms, etc

3. Do you know your blood pressure readings were at diagnosis ? **YES/NO**
If YES, please provide details.

4. Do you know the cause for your high blood pressure ? If YES, provide details **YES/NO**

5. Have you had an ECG, x-ray, blood lipid test or other investigations ? **YES/NO**
If YES, please provide details including dates of investigations and results.

6. Please provide details of your treatment. Include names of medication (eg Diuretics, Amlodipine, Atenolol, Metaprolol, Propanolol, Losartan, Enalapril, Ramipril, Telmisartan, Olmesartan etc), dosage and how often taken :
 - a Currently: _____
 - b In the past: _____
7. Regarding the monitoring of your condition:
 - a Provide name of your Doctor : _____
 - b How often do you attend Doctor for follow-up ? _____
 - c When was your last consultation ? Please provide details of your blood pressure reading at that time, if known.

8. Have any abnormalities (eg protein, blood, etc) ever been found in your urine ? **YES/NO**
If YES, please provide date(s) and full details.

9. Do you smoke cigarettes ? If YES, how many per day ? **YES/NO**

10. Have you ever been hospitalized or been out from your work for long time due to this condition ? **YES/NO**
If YES, please provide details including dates and duration of time off work.

11. Please provide any additional information on your condition which you feel will be helpful in processing your application.

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 agree that this form will constitute part of my application for life assurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of applicant

Date

Note: Please attached all treatment related papers with all investigations and Follow ups.