Digestive System Diseases other than cancer

Disease: Please select from the below, the specific condition that applies to the insured

☐	Inflammatory Disease	☐	Liver Disease
☐	Divericular Disease	☐	Pancreatitis
☐	Gall Bladder Disease		

General Information

Last Name:	First Name:	
Date of Birth:	Age:	Sex:
Height : Cm	Weight: Kg	
Do you smoke? Yes ☐ No ☐	For how many years?	
If yes, how many cigarettes per day? If No, did you ever smoke? Yes ☐ No ☐	When did you stop?	
-Do you drink? If yes, what? Yes ☐ No ☐	If yes, how many drinks per day?	For How many years?
	If No, did you ever drink? Yes ☐ No ☐	When did you stop?
Name, address and telephone number of present attending Physician:		
Frequency of visits to physician:	Date of last visit: / /	
What is your disease? ☐ Inflammatory ☐ Gall Bladder ☐ Pancreatitis ☐ Diverticular ☐ Liver Disease		

Condition Profile

At what age were you told you had the disease?		
What were the first symptoms?		
☐ Bleeding ☐ Pain	☐ Diarrhea /Constipation ☐ Nausea or Vomiting	☐ Icterus ☐ Other: __________
What test(s) have been done to diagnose your disease? ☐ Gastroscopy Year.............. ☐ Colonoscopy Year.............. ☐ Ultrasound Year.............. ☐ CT Scan Year.............. ☐ Biposy Year.............. ☐ Other Year..............		Last Hemoglobin Reading and date: _________________ Date: __/__/______ Last Hematocrit Reading and date: _________________ Date: __/__/______ Have you ever Had a transfusion? Yes ☐ No ☐ Quantity: ____ Date: __/__/____
Have you ever had high Cholesterol level?What is your current Cholesterol level? ☐<200mg/dl ☐ 200 mg/dl or more		Have you ever had high Triglyceride level? What is your current Triglyceride level? ☐<250 mg/dl ☐ 250 mg/dl or more

Treatment:

- Diet:
- Medication (Name and dosage):
  - .
  - .
  - .
- Insulin
- Surgery; If yes, when and what was the procedure
- Have you ever been hospitalized for the disease?

Has treatment changed during the last five years? Yes ☐ No ☐
If yes, describe the change:

Please continue filling in the next page

Digestive System Diseases other than cancer (cont'd)

<table>
<tr><td>Do you have Crohn's Disease or Ulcerative Colitis? Yes ☐ No ☐. If Yes:
How often do you have attacks?____
Are the attacks becoming more frequent?
Yes ☐ No ☐
Are you on Steroids?
Yes ☐ No ☐
For how long on Steroids? ____</td><td>Do you have a liver problem? Yes ☐ No ☐. If Yes:

AST/SGOT date: __/__/____ Result:____
ALT/SGPT date: __/__/____ Result:____
GGT date: __/__/____ Result: ____
PT date: __/__/____ Result: ____
Hepatitis A ☐, B ☐, C ☐, Other ☐ ____</td></tr>
<tr><td colspan="2">Please check the illnesses below that you have ever had:</td></tr>
<tr><td>☐ Stroke Year…………….
☐ Heart Rhythm Problem Year…………….
☐ Liver Problem Year…………….
☐ Kidney Disease Year…………….</td><td>☐ Edema Year…………….
☐ Eye trouble Year…………….
☐ Ulcer Disease Year…………….
☐ Other?............................. Year…………….</td></tr>
<tr><td colspan="2">Do other members of your family have Hypertension? Yes ☐ No ☐ (if a parent is deceased, please list the cause of the death)</td></tr>
<tr><td colspan="2">If yes, who and what is the disease?
-
-</td></tr>
</table>

Attending Physician:-------------------------- Date ---------/------------/------------

I hereby, give full and irrevocable authorization to the Insuranec Company, to the Administrator and to MedNet Delegates' (Physician and Nurses), to inquire about my actual state of health and that of my dependants from any Medical Center or Hospital or Doctor, and I waive my right of medical confidentiality to the benefit of the Insurance Company, the Administrator and MedNet Delegates'. Failure to disclose material information, whether by omission or false declaration, which the Insurance Company should have known, the latter will have the right to cancel my or my dependents' rights in coverage starting from the effective date of the policy without having any financial obligation.

Insured's Signature:-------------------------------- Date -----------/------------/----------