Respiratory Diseases other than cancer

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

☐	Asthma	☐	Interstitial Lung Diseases
☐	Chronic Obstructive Pulmonary Disease	☐	

General Information

Last Name:	First Name:
Date of Birth:	Age: Sex:
Height : Cm	Weight: Kg
Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes per day? If No, did you ever smoke? Yes ☐ No ☐	For how many years? 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? ☐ Emphysema ☐ Chronic Bronchitis ☐ Asthma ☐ Restrictive Lung Disease	What is the severity of the Disease? Mild ☐ Moderate ☐ Severe ☐ Coughing of Blood: Yes ☐ No ☐ Coughing of Sputum: Yes ☐ No ☐

Condition Profile

At what Age were you told you had a Respiratory Disease?

Has a Pulmonary Test (Breathing test, Spirometry...) ever been done?:
-Test Name: Result: Date:
-Test Name: Result: Date:

Treatment:
- ❖ Medication (Name and dosage):
  1. .
  2. .
  3. .
- ❖ Oxygenotherapy Yes ☐ No ☐
- ❖ Nebulizer Yes ☐ No ☐
- ❖ Inhaler Yes ☐ No ☐

Have you ever been hospitalized or got to the emergency room for this condition?

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

Please check the illnesses below that you have ever had:

☐ Stroke	Year……	☐ Edema	Year……
☐ Heart Rhythm Problem	Year……	☐ Eye trouble	Year……
☐ Liver Problem	Year……	☐ Ulcer Disease	Year……
☐ Kidney Disease	Year……	☐ Other?.....	Year……

Do other members of your family have Respiratory Disease? Yes ☐ No ☐ (if a parent is deceased, please list the cause of the death)

If yes, who and what is the disease?
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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 ----------/----------/----------