Digestive System Disease *(other than cancer)*

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

☐ Crohn's Disease	☐ Diverticular Disease	☐ Gall Bladder Disease	☐ Pancreatitis
☐ Hirshsprung	☐ Ulcer Disease	☐ Weight Control Procedure	☐ Liver Disease
☐ Ulcerative Colitis	☐ Stomach Problem	☐ Food Intolerance	☐ Other _____

General Information

Last Name: _____ First Name: _____ Occupation: _____
Date of Birth: _____ Age : _____ Sex: _____
Height: _____ Cm Weight : _____ Kg BMI: _____

Name, address and telephone number of present attending physician:

_____
_____

Frequency of visits to physician: ☐ Occasionally ☐ Frequently
Date of last visit: ___ /___ /___

Do you smoke? ☐Yes ☐ No If Yes, how many cigarettes per day? _____
For how many years? _____
Did you ever smoke? ☐Yes ☐ No If Yes, when did you stop? _____

Do you drink? ☐Yes ☐ No If Yes, how many drinks per day? _____
For how many years? _____
Did you ever drink? ☐Yes ☐ No If Yes, when did you stop? _____

Condition Profile

At what age were you told you had the Disease? _____
What were the first symptoms:

☐ Bleeding	☐ Icterus	☐ Diarrhea/Constipation	☐ Pain
☐ Nausea or Vomiting	☐ Loss of weight	☐ Other _____	

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? _____
Do you have a liver problem? Yes ☐ No ☐
If Yes?

AST/SGOT	date: ___ /___ /___	Result: _____		ALT/SGPT	date: ___ /___ /___	Result: _____	
GGT	date: ___ /___ /___	Result: _____			date: ___ /___ /___	Result: _____	

Hepatitis ☐ A ☐ B ☐ C ☐ Other _____

What test(s) have you completed to diagnose your Disease?

☐ Gastroscopy	……. Year	☐ Colonoscopy	…….. Year
☐ Ultrasound	……. Year	☐ CT Scan	…….. Year
☐ Biopsy	……. 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: ___ /___ /___

What is your current Cholesterol level? ☐ <200mg/dl ☐ 200 mg/dl or more
☐ <200mg/dl ☐ 200 mg/dl or more

What is your current Triglyceride level?

Diastolic	☐ ≤80 ☐ 80 – 90 ☐ 90	Systolic	☐ ≤130 ☐ 130 – 140 ☐ 140	HbA1c	☐ < 7% ☐ ≥ 7%	Hepatitis B or C	☐ Yes ☐ No

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Treatment

- * Diet ☐ * Insulin ☐
- Medication (Name and dosage):
  1. _____
  2. _____
  3. _____

* Surgery: Yes ☐ No ☐

If Yes, when and what was the procedure?_____
Have you ever been hospitalized for the disease? ☐Yes ☐ No When: _____

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

Attending Physician: ……. Date: ___ /___ /___

I hereby declare that the above mentioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the policy contract, in favor of the Medical committees and doctors, requesting from them, and other insurance companies or any other guarantor which we had contracted with for medical and/or life insurance, to provide the insurance company and/or GlobeMed Lebanon with all the information and documents available at their side on our medical condition and of copies thereto, permitting GlobeMed Lebanon, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers, with all possible means, either through e-mail, or SMS or any other available mean.

Insured's Signature: ……. Date: ___ /___ /___