Neoplasm Questionnaire

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

☐ Lung ☐Breast ☐Prostate ☐Colon ☐Gastric ☐Esophageal ☐Gynecology
☐Bladder ☐Hepatic ☐Pancreatic ☐Lymphoma ☐Leukemia ☐ENT ☐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: ___ /___ /___

What is the severity of the Disease? ☐ Mild ☐ Moderate ☐ Severe ☐ Cured

Coughing of Blood: ☐Yes ☐ No
Coughing of Sputum: ☐Yes ☐ No

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? _____

Condition Profile

At what Age were you told you had a Cancer? _____
What was the type of Cancer? _____
What was the stage/Grade? _____ T ☐ N ☐ M ☐
Had the Cancer spread the original site or were the Lymph Nodes involved? ☐Yes ☐ No
If Yes, Please Explain: _____
Has there been any evidence of Recurrence? Yes ☐ No ☐
If Yes, Please Explain: _____

Basis of Diagnosis

1. Biopsy / Surgery ☐
2. Scan ☐
3. Specific biochemical test ☐
4. Others ☐

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

Treatment

- Medication (Name and dosage):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

- Chemotherapy Yes ☐ No Starting Date: __ /__ /__ Last treatment: __ /__ /__ # of Cycles: _____
- Surgery Yes ☐ No Date: __ /__ /__ Procedure Type:_____
- Radiation Therapy Yes ☐ No Starting Date: __ /__ /__ Last treatment: __ /__ /__ # of Cycles: _____
- Hormonal Therapy Yes ☐ No Starting Date: __ /__ /__ Last treatment: __ /__ /__ # of Cycles: _____

Last results of Tumor Markers

AFP …… Date: ___ /___ /___
HCG …… Date: ___ /___ /___
CEA …… Date: ___ /___ /___
CA19-9 …… Date: ___ /___ /___
Hemoglobin …… Date: ___ /___ /___
CA15-3 …… Date: ___ /___ /___
Creatinine …… Date: ___ /___ /___
PSA …… Date: ___ /___ /___
Other (Please Specify): …… Date: ___ /___ /___

Neoplasm Questionnaire

Please check the illnesses below that you have ever had:

☐ Stroke	…….. Year	☐ Eye trouble	…….. Year
☐ Heart Rhythm Problem	…….. Year	☐ Ulcer Disease	…….. Year
☐ Liver Problem	…….. Year	☐ Hepatitis B or C	…….. Year
☐ Kidney Disease	…….. Year	☐ Other _____	…….. Year
☐ Edema	…….. Year		

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

_____

If yes, who and what is the type? _____

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: ___ /___ /___