Respiratory Disease Questionnaire

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

☐ Asthma ☐ Chronic Obstructive Pulmonary Disease
☐ Chronic Bronchitis ☐ History of Tuberculosis ☐ 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 Respiratory Disease? ____

Has a Pulmonary Test (Breathing test, Spirometry...) ever been done? ☐Yes ☐ No

1. Test Name: _____________________________ Result: ________________ Date ___ /___ /___
2. Test Name: _____________________________ Result: ________________ Date ___ /___ /___

Treatment

- Medication (Name and dosage):

1. _____________________________
2. _____________________________
3. _____________________________
4. _____________________________

- Oxygenothepay ☐Yes☐ No
- Nebulizer ☐Yes☐ No
- Inhaler ☐Yes☐ No
- Corticotherapy ☐Yes☐ No

Have you ever been hospitalized or got to the emergency room for this condition? ☐Yes ☐ No
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 ☐ Heart Problem …….. Year
☐ Kidney Disease …….. Year ☐ Liver Problem …….. Year
☐ Other ___________________ …….. Year
Do other members of your family have Respiratory Disease? Yes ☐ No ☐
(If a parent is deceased, please list the cause of death)
____

If yes, who and reason? ____

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: ___ /___ /___