Anemia Questionnaire

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

☐ Sickle cell anemia ☐ Iron Deficiency anemia ☐Myelodysplasia ☐ Others _____

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 type of Anemia do you have? _____

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 Anemia? _____
What caused the Anemia? _____

What test(s) have been done to diagnose the Anemia?
☐ Thick smear ……Year ☐ Bone marrow ……Year ☐ Iron, TIBG ……Year ☐ Other(s) ……Year

Last Hemoglobin reading: …….. Date: ___ /___ /___
Last Hematocrit Reading: ……Date: ___ /___ /___

Have you ever had high Cholesterol level? What is your current Cholesterol level? ☐< 200mg/dl ☐ 200 mg/dl or more

Treatment

- Medication (Name and dosage):

1. _____
2. _____
3. _____

- Transfusion (Date): ___ /___ /___
- Splenectomy (Date): ___ /___ /___

Have you ever been hospitalized for Anemia? Yes ☐ No ☐
Has treatment changed during the last year? Yes ☐ No ☐
If yes, describe the change: _____

Vaccination:
Have you received any vaccination in the last 5 years? _____

Please check the illnesses below that you have ever had:

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

Do other members of your family have Anemia? Yes ☐ No ☐
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: ___ /___ /___