Medical Questionnaire for Disability Insurance Eligibility

Personal Information

Full Name

Date of Birth

Gender

Select...

Contact Number

Address

Medical History

Have you ever been diagnosed with any of the following? (Check all that apply)

- [ ] Heart Disease
- [ ] Diabetes
- [ ] Cancer
- [ ] Stroke
- [ ] Mental Health Conditions
- [ ] Other

Please list any other diagnosed conditions

Are you currently under any medical treatment or medication?

- ( ) Yes
- ( ) No

If yes, please specify medications/treatments

Disability Details

Please describe your disability and how it affects your daily life

Date Disability Began (if applicable)

Name and Contact of Treating Physician

Declaration

☐ I declare that the information provided is true and complete to the best of my knowledge.

Date

Signature