Standard Medical Questionnaire for Critical Illness Underwriting

Personal Information

Full Name

Date of Birth

Gender

Select

Address

Contact Number

Email

Occupation

Medical History

Have you ever been diagnosed with, or treated for, any of the following conditions?

- [ ] Heart
- [ ] Stroke
- [ ] Cance
- [ ] Kidne
- [ ] Other

If 'Other', please specify

Do you have any chronic medical condition?

- ( ) Yes
- ( ) No

If yes, please provide details

Are you currently taking any medication?

- Yes
- No

If yes, please provide name and dosage

Lifestyle Information

Do you smoke?

- Yes
- No
- Forme

If yes, please specify quantity and duration

Do you consume alcohol?

- Yes
- No
- Forme

If yes, please specify frequency and amount

Height (cm)

Weight (kg)

Family Medical History

Has any of your immediate family (father, mother, siblings) had any of the following conditions?

- [ ] Heart
- [ ] Stroke
- [ ] Cance
- [ ] Diabe
- [ ] None

If yes, please specify relationship and age at diagnosis

Declaration

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

Signature

Date