# BAF INSURANCE COMPANY (CAYMAN) LIMITED
# HEART DISEASE AND HYPERTENSION QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

## ① PATIENT'S INFORMATION

| Name | | | Date of birth |
|---|---|---|---|
| Last | First | M.I. | / / Month Day Year |

## ② DIAGNOSIS

Please provide details about when the condition was diagnosed

| Date of first visit | Details |
|---|---|
| / / Month Day Year | Symptoms: _____ Diagnosis: _____ |

Has the patient suffered any of the following symptoms? If "Yes", please explain.

| Symptom | | Date of first symptom | Severity | Frequency |
|---|---|---|---|---|
| Shortness of breath | ❍ Yes ❍ No | / / Month Day Year | | |
| Chest pain | ❍ Yes ❍ No | / / Month Day Year | | |
| Loss of consciousness | ❍ Yes ❍ No | / / Month Day Year | | |
| Dizziness | ❍ Yes ❍ No | / / Month Day Year | | |
| Palpitations | ❍ Yes ❍ No | / / Month Day Year | | |
| Other | ❍ Yes ❍ No | / / Month Day Year | | |

Has the patient undergone cardiovascular surgical intervention? If "Yes", please provide details. ❍ Yes ❍ No

Is the patient undergoing treatment? If "Yes", please provide details, name of medication and dosage. ❍ Yes ❍ No

Please provide the following information

| Date | Height | Weight | Blood pressure |
|---|---|---|---|
| / / Month Day Year | ❍M ❍Ft | ❍Kg ❍Lb | |

Values of blood test results performed within the past 6 months

| | | | | |
|---|---|---|---|---|
| Glucose | Glyco hemoglobin | Creatinine | Potassium | Sodium |
| Total cholesterol | LDL | HDL | Triglycerides | Funduscopy |

Specimen test results performed within the past 6 months

| Urine | Blood | Sugar | Albumin |
|---|---|---|---|
| | | | |

Please enclose EKG and chest X-ray interpretations performed within the past 12 months. In case of mitral valve prolapsed or other valve disorders, please enclose results of echocardiogram.

| | | | |
|---|---|---|---|
| EKG result | | Date | / / Month Day Year |
| Chest X-ray result | | Date | / / Month Day Year |

Please continue on next page

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)

| Study | | Date | Result |
|---|---|---|---|
| Echocardiogram | ❍ Yes ❍ No | / / Month Day Year | |
| Stress test (treadmill) | ❍ Yes ❍ No | / / Month Day Year | |
| Myocardial scintigraphy | ❍ Yes ❍ No | / / Month Day Year | |
| Creatinine clearance | ❍ Yes ❍ No | / / Month Day Year | |
| Other _____ | ❍ Yes ❍ No | / / Month Day Year | |

| History of smoking | | Other comments |
|---|---|---|
| Amount per day | Number of years | |
| | | |

Does the patient have any relatives that suffer or have suffered from cardiovascular disease or arteriosclerosis before the age of 55? If "Yes", please explain. ❍ Yes ❍ No

Are there any other relevant factors, diseases, symptoms, or complications not previously mentioned? ❍ Yes ❍ No
If "Yes", please explain.

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? ❍ Yes ❍ No
If "Yes", please the information requested below.

Physician's name: _____ (Last First M.I.) Telephone number: ( )

Outpatient treatment: _____

Hospital: _____ Telephone number: ( )

Hospital treatment: _____

## ③ TREATING PHYSICIAN'S INFORMATION

Name: _____ (Last First M.I.)

Address: _____

Telephone number: ( ) _____ Fax number: ( ) _____ Email:

| Date | Signature |
|---|---|
| / / Month Day Year | |