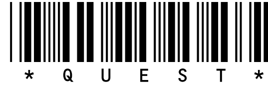

Hypertension Supplementary Questionnaire (Q34)

Particulars of Life Assured

Name : ____

Identity Card / Passport No. : ______________________ Contract No. : __________

Medical Questions

1. When were you diagnosed with high blood pressure?

   ____

2. What was your blood pressure reading at that time?

   ____

3. Was your high blood pressure caused by anything specific (eg stress, pregnancy, overweight, other conditions)?

   ☐ Yes ☐ No

   If '**Yes**', please provide details: ______________________________

4. What treatment was or has been prescribed by your doctor?

   Please tick accordingly and provide details:

   ☐ **Oral Medication**

Name of Medication	Dosage	Frequency	Start Date of Medication	End Date of Medication (if applicable)

☐ **Diet and exercise only**

☐ **Others**, please provide details: ______________________________

Please specify date of last treatment (if applicable): ______________________

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5. Has your blood pressure returned to normal with no further symptoms or treatment required?

☐ Yes ☐ No

If ‘**Yes**’, when did your blood pressure return to normal?

____

6. How frequent do you have your blood pressure monitored by your doctor?

____

7. When was your last consultation for blood pressure monitoring and what was your blood pressure reading at this consultation?

Date of Consultation: ____________________ (dd/mm/yyyy) Reading: __________________ (mmHg)

8. Have you undergone any investigations or tests (ie ECG, urine tests, blood tests, vision tests), to check for complications or other conditions such as raised cholesterol, diabetes, kidney disorder or heart disease?

☐ Yes ☐ No

If ‘**Yes**’, please provide details:

Type of Investigation / Test	Date	Results*
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal
		☐ Normal ☐ Abnormal

* For abnormal results, please provide details: ____

____

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9. Do you have the following complications as a result of your high blood pressure? Please tick accordingly.

(a) Kidney Problems? ☐ Yes ☐ No

If '**Yes**', please provide details: ____________________

(b) Protein or albumin in your urine? ☐ Yes ☐ No

If '**Yes**', please provide details: ____________________

(c) Heart or circulatory problems? ☐ Yes ☐ No

If '**Yes**', please provide details: ____________________

(d) Vision problems? ☐ Yes ☐ No

If '**Yes**', please provide details: ____________________

(e) Others? ☐ Yes ☐ No

If '**Yes**', please provide details: ____________________

10. Please provide the name and address of the doctor / clinic / hospital which you have consulted for this condition.

Name of Doctor / Clinic / Hospital	Address	Date of Last Consultation

Note: Please provide us with copies of all medical reports relating to this condition, if available.

Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our health status between the date of this Declaration and the date full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above information shall form the basis of my/our application for insurance. I/We declare that the information given is true and complete and I/we have not withheld any material information that may influence the assessment of my/our application.

____________________ ____________________
Name and Signature of Life Assured Date (dd/mm/yyyy)

____________________ ____________________
Name and Signature of Assured Date (dd/mm/yyyy)

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