HEART DISEASE AND HYPERTENSION QUESTIONNAIRE

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

Bupa

1. APPLICANT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed:

Date of first visit	Symptoms	
MM / DD / YY	Diagnosis	

Has the patient suffered any of the following symptoms? ☐ Yes ☐ No If "Yes", please explain.

Symptom		Date of first symptom	Severity	Frequency
Shortness of breath	☐ Yes ☐ No	MM / DD / YY		
Chest pain	☐ Yes ☐ No	MM / DD / YY		
Loss of consciousness	☐ Yes ☐ No	MM / DD / YY		
Dizziness	☐ Yes ☐ No	MM / DD / YY		
Palpitations	☐ Yes ☐ No	MM / DD / YY		
Other	☐ Yes ☐ No	MM / DD / YY		

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

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

Please provide the following information:

Date	MM / DD / YY	Height ☐ M ☐ Ft		Weight ☐ Kg ☐ Lb		Blood pressure	

Values of blood test results performed within the past 6 months:

Glucose		Glyco hemoglobin		Creatinine		Potassium		Sodium	
Total cholesterol		LDL		HDL		Triglycerides		Fundoscopy	

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	MM / DD / YY
Chest X-ray result		Date	MM / DD / YY

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)			
Study		Date	Result
Echocardiogram	☐ Yes ☐ No	MM / DD / YY	
Stress test (treadmill)	☐ Yes ☐ No	MM / DD / YY	
Myocardial scintigraphy	☐ Yes ☐ No	MM / DD / YY	
Creatinine clearance	☐ Yes ☐ No	MM / DD / YY	
Other	☐ Yes ☐ No	MM / DD / YY	

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? ☐ Yes ☐ No
If "Yes", please explain.

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		Telephone	
Outpatient treatment			
Hospital		Telephone	
Hospital treatment			

3. TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
Email			
Signature		Date	MM / DD / YY

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