HEALTH PROFILE QUESTIONNAIRE

JUST.

A

Personal Details (Fields marked with * are required)

Name and surname

Identity number

Date of birth D D M M Y Y Y Y

Height (in cm)* cm or ft

Weight (in kg)* kg or lb Clothing size

Sex ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Are you the main applicant or the spouse of the main applicant? ☐ Main applicant ☐ Spouse

Doctor's name: Doctor's contact number:

If we have queries about any of your information, we will need to contact you. Please supply:

Your preferred contact number

The time of day that is most convenient for you to take our call

If someone is completing this questionnaire on your behalf, they need to state their relationship to you here:

Monthly household income before tax* R:

Occupation: If medically boarded, state reason:

Employer:

Highest level of education*:

☐ Up to Standard 8
☐ Standard 8 / Standard 9
☐ Matric
☐ 3 year diploma / B-Tech
☐ University degree / professional

Do you belong to a medical scheme? ☐ Yes ☐ No

If you ticked yes, what medical scheme do you belong to?

Do you drink alcohol? ☐ Yes ☐ No

If you ticked yes please supply the number of units per week units

Where 1 unit is 250ml beer, a standard glass of wine (175ml) or 25ml spirits (1 tot)

If you need to add more detail to any of your answers in Section 1, please use this box.

B

Health details

1 Do you smoke? ☐ Yes ☐ No

If you ticked yes, please answer 1a, 1b and/or 1c:

1a) When did you start smoking? Y Y Y Y

1b) If you smoke manufactured cigarettes, how many cigarettes do you smoke per day on average?

1c) If you smoke hand-rolled cigarettes or pipe, how much tobacco do you smoke per week? grams

JUST.

B

Health details continued

2 Have you ever been diagnosed with a heart condition? ☐ Yes ☐ No

If you ticked yes, please answer 2a:

2a) What heart condition/s were you diagnosed with? Please supply date/s of diagnosis.

☐ Chest pains confirmed as angina Date of diagnosis: M M Y Y Y Y

☐ Coronary artery disease (furring up of the coronary arteries) Date of diagnosis: M M Y Y Y Y

☐ Heart attack Date of heart attack: M M Y Y Y Y

If more than one heart attack, please supply dates: M M Y Y Y Y M M Y Y Y Y

M M Y Y Y Y

If you ticked ANY of the options in 2a, please answer 2b, 2c and 2d:

2b) When did you last suffer chest pains due to this condition? M M Y Y Y Y

2c) Have you had bypass surgery? ☐ Yes ☐ No

Most recent procedure date: M M Y Y Y Y

2d) Have you had stents or balloon angioplasty? ☐ Yes ☐ No

Most recent procedure date: M M Y Y Y Y

If you ticked yes to 2c or 2d, please answer 2e:

2e) How many arteries were treated in the most recent procedure?

1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Any additional information

3 Have you ever been diagnosed with diabetes? ☐ Yes ☐ No

If you ticked yes, please answer 3a, 3b and 3c:

3a) When was your diabetes diagnosed? M M Y Y Y Y

3b) How do you control your diabetes? Tick all that apply: By

☐ Diet

☐ By tablets

☐ By insulin

☐ Other. Please specify:

3c) What is your most recent **HbA1c** reading** measured at a clinic, if known?

** This is NOT the same as your daily glucose reading.

Any additional information

4 Have you ever been admitted to hospital with a stroke (where symptoms lasted more than 24 hours)?

☐ Yes ☐ No

If you ticked yes, please answer 4a, 4b, 4c and 4d:

4a) What type/s of stroke did you have?

☐ Transient Ischaemic Attack (TIA)

☐ Cerebral Thrombosis or Embolism

☐ Cerebral Haemorrhage

☐ Subarachnoid Haemorrhage

☐ Aneurysm or AV Malformation that is still present

☐ Not sure

4b) When was the last time this happened? M M Y Y Y Y

4c) Do you still experience any of the following symptoms?

i) Unable to walk without assistance ☐ Yes ☐ No

ii) Bladder/bowel accident once a week or more ☐ Yes ☐ No

4d) Do you still require assistance with dressing, feeding or bathing? ☐ Yes ☐ No

Any additional information

B

Health details continued

5 Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If you ticked yes, please answer 5a, 5b, 5c, 5d and 5e.

If you have had more than one unrelated occurrence of cancer in the last 10 years, please use Section 8 to give details of any other cancer.

5a) What was the name or type of cancer and where was it located?

5b) When was this diagnosed? ☐☐☐☐☐☐

5c) What treatment did you receive? (tick all that apply)

☐ Surgery ☐ Radiotherapy
☐ Chemotherapy ☐ Other. Please specify:

5d) Did the cancer spread? ☐ Yes ☐ No

If you ticked yes, please indicate where it spread to:

☐ to lymph nodes
☐ to other organs/other parts of the body. Please specify:

5e) Please provide any information you have been supplied about your cancer's stage (e.g. Stage 1, Stage 2, etc, or TNM classification or Dukes Stage) and grade (e.g. Grade 1, Grade 2, etc):

Any additional information

6 Have you ever been diagnosed with a chronic (ongoing) lung condition? ☐ Yes ☐ No

If you ticked yes, please answer 6a, 6b, 6c and 6d:

6a) What lung condition/s have you been diagnosed with, and when was this diagnosed?

☐ Asthma
Date of diagnosis: M M Y Y Y Y

☐ Chronic Obstructive Pulmonary Disorder (COPD), bronchitis or emphysema Date of diagnosis: M M Y Y Y Y

☐ Pneumoconiosis or asbestosis (linked to coal dust or asbestos exposure) Date of diagnosis: M M Y Y Y Y

☐ Tuberculosis (TB) Date of diagnosis: M M Y Y Y Y

☐ Other. Please specify:

Date of diagnosis: M M Y Y Y Y

6b) What is your current lung function capacity, as measured by your doctor or nurse in terms of FEV1 (Forced Expiratory Volume in 1 second), if known? ☐☐ %

6c) Do you require oral steroids daily for your condition? ☐ Yes ☐ No

6d) Have you required home oxygen on a continuous daily basis for 15 hours per day for at least the last 6 months? ☐ Yes ☐ No

Any additional information

B

Health details continued

7 Please provide a list of all medications you are currently prescribed:

Medication name	Dosage	Frequency[1]	Condition being treated	Diagnosis date

[1] If directed to use "as required", how often do you require it on average?

Any additional information

8 Aside from the conditions covered elsewhere on this questionnaire, please list any other conditions that you have or had, such as high blood pressure or cholesterol? Please also state any hospital admissions in the last 5 years.

Nature of condition:	Treatment:	Diagnosis date:
		D D M M Y Y Y Y
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		D D M M Y Y Y Y
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DISCLAIMER

Your personal information, including information regarding your health, is confidential. We will only use this information in order to do underwriting, business analysis and research. We will not give your information to third parties or use it for marketing purposes without your permission.

To the best of my knowledge, the information that I have provided is accurate and complete.

Signature

D D M M Y Y Y Y

Date