Sagicor

BLOOD PRESSURE QUESTIONNAIRE

Name of Proposed Insured:	Policy No:
Occupation:	Date of Birth: (DD/MM/YY)

1. Have you ever been told that your blood pressure was elevated? ☐ Yes ☐ No

   If "Yes" give date and reading(s)

Day Month Year	Reading(s)

2. a. When did you last have your blood pressure measured? _____

2. b. Do you know what your blood pressure was on this occasion? ☐ Yes ☐ No

   If "Yes", give dates and BP reading?

   _____

3. Do you currently take any medication to lower your blood pressure? ☐ Yes ☐ No

   If "Yes", please provide details including names, dosages and frequency:

Name of medication	Dose	Frequency	When did you start taking this?

4. Please provide the name and address of the doctors and/or specialists you have seen in relation to your raised blood pressure.

Name of doctor, hospital or clinic	Addresses	Date late consult

5. Other than already stated above, have you ever taken any other medication to lower your blood pressure? If yes, please provide details: ☐ Yes ☐ No

Name of medication or treatment	Dose	Frequency	When did you stop taking this?

6. Have you ever had any related tests or investigations e.g. blood test, 24 hour blood pressure recording, electrocardiogram, echocardiogram, urine test etc.? If yes, please provide details: ☐ Yes ☐ No

Name of test or investigation	Location	Date	Results

7. Do you suffer from any related problems e.g. raised cholesterol, diabetes mellitus, heart, kidney or eye problems? If yes, please provide details: ☐ Yes ☐ No

_____

8. Other than regular monitoring of your blood pressure, has any future treatment or investigation been discussed or contemplated? If yes, please provide details: ☐ Yes ☐ No

_____

9. Please provide any additional information that you feel is important.

_____

I declare that the above statements are full, complete and true, and agree that they shall form a part of my application for the policy, I hereby authorize any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment, or any hospital or clinic where I have been a patient for diagnosis, treatment, disease or ailment, or any insurance company to which I have applied or other organization, institution or person that has any record or knowledge of me or my health, to give full particulars, including any prior medical history, to **Sagicor Life Insurance Trinidad & Tobago Limited.**

A photocopy of this authorization shall be as valid as the original.

Dated at_____ this_____ day of_____ 20 _____

_____ Signature of Proposed Insured

_____ Signature of Medical Examiner

EXAMINER'S REPORT				
	Time	**Systolic**	**Diastolic**	**Pulse**
1. Blood Pressure	am/pm			
2. Additional Readings (Current) to be taken 20 minutes apart or on different days				
Date	**Time**	**Systolic**	**Diastolic (Cessation of Sound)**	**Pulse**
	am/pm			
	am/pm			

3. Are there any abnormal signs in the fundoscopic examination of the retina? ☐ Yes ☐ No

4. Remarks_____

_____ Signature of Examiner

_____ Doctor's Stamp

_____ Date