Medical Questionnaire: Kidney-related Conditions

Name of Life Assured :

NRIC of Life Assured :

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- ☐ Renal dialysis (hemodialysis / peritoneal dialysis) report
- ☐ Dialysis receipts
- ☐ Renal transplantation report
- ☐ Renal Function Test with eGFR results over past 6-9 months
- ☐ Lupus Erythematosus (LE) cell blood test results
- ☐ Anti-DNA Antibodies
- ☐ Urine FEME results over past 6 months
- ☐ Renal biopsy report
- ☐ Other reports. Please give details: _____

1. Are you the Life Assured's usual medical attendant? ☐ No ☐ Yes

   If "YES", since what date? ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

2. Has the Life Assured previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?

   ☐ No ☐ Yes

   If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name of Clinic/ Hospital and Address

3. Date when Life Assured FIRST consulted you for the illness. ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Life Assured had been experiencing these symptoms.

Symptoms	Date symptoms first started (dd/mm/yyyy)
(a)	
(b)	

   What is the source of this information?

   - ☐ Patient
   - ☐ Referring doctor
     Name of doctor and hospital / clinic : _____
   - ☐ Others, please specify : _____

5. Diagnosis

   (i) Please describe the full and exact diagnosis. (i) _____

   (ii) Date when the illness was FIRST diagnosed (ii) ☐☐/ ☐☐/ ☐☐☐☐ (dd/mm/yyyy)

   (iii) Diagnosis was FIRST made by (name of doctor and hospital) (iii) _____

   (iv) Date when Life Assured FIRST became aware of the illness. (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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6.	What is the underlying cause of the illness? When was the underlying cause FIRST diagnosed?	_____ _____ ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) Name of treating doctor and clinic / hospital. _____ _____
7.	Type of investigations / tests done to confirm the diagnosis.	_____ _____
8.	Please give details of completed, planned or current treatment for the illness stated above.	_____ _____ _____
9. (i)	Does the Life Assured have end-stage renal failure?	(i) ☐ No ☐ Yes
(ii)	Is the renal failure irreversible?	(ii) ☐ No ☐ Yes
(iii)	Is the renal failure acute or chronic?	(iii) ☐ Acute ☐ Chronic
(iv)	When was the Life Assured FIRST diagnosed to have <u>early</u> chronic kidney disease?	(iv) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
10. (i)	Is the Life Assured currently undergoing regular peritoneal dialysis or haemodialysis?	(i) ☐ No ☐ Yes
(ii)	Please state the date dialysis was FIRST started.	(ii) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
11. (i)	Has the Life Assured undergone a kidney transplant?	(i) ☐ No ☐ Yes
(ii)	Please state the date of transplantation	(ii) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
12. (i)	If the kidney disease is due to Systemic Lupus Erythematosus (SLE), please indicate the WHO classification of the Type of Lupus Nephritis as confirmed by renal biopsy:	(i) ☐ Type I – Minimal change glomerulonephritis ☐ Type II – Mesangial glomerulonephritis ☐ Type III – Focal Segmental glomerulonephritis ☐ Type IV – Diffuse glomerulonephritis ☐ Type V – Membranous glomerulonephritis
(ii)	The SLE involves the following areas or organs:	(ii) ☐ Blood ☐ Joints ☐ Kidneys ☐ Skin ☐ Lungs ☐ Others : _____
(iii)	When was the FIRST abnormal blood test detected?	(iii) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) Name of doctor and clinic / hospital. _____
(iv)	Was the Life Assured been informed of the abnormal blood test results?	(iv) ☐ No ☐ Yes
(v)	Was the Life Assured advised to perform additional tests when the above abnormal results were detected?	(v) ☐ No ☐ Yes If "Yes", please give full details _____

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13. If copies of Renal Function Test results are not available, please state detailed results and dates below:

Renal Function Tests	Date: _____	Date: _____	Date: _____	Date: _____
Serum creatinine				
Serum urea				
eGFR				
Urine FEME				
Others				

TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

Signature and Official Stamp

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Name : _____

Address : _____

_____

_____

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