Medical Questionnaire: Liver-related Conditions

Name of Life Assured :

NRIC of Life Assured :

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

- ☐ Liver Function Test – all test results done over past 6-9 months
- ☐ Hepatitis viral serology test
- ☐ Ultrasound abdomen with report – all test results over past 6-9 months
- ☐ Liver biopsy
- ☐ CT scan of liver
- ☐ Other blood and laboratory test results to confirm diagnosis and underlying cause of liver failure
- ☐ 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)

GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A)
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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)	If the liver disease is caused by viral hepatitis, what is the type of virus involved?	(i) _____
(ii)	Is the liver disease associated with drug or alcohol misuse?	(ii) ☐ No ☐ Yes If "YES", please provide details. _____
(iii)	When was the Life Assured FIRST diagnosed to have <u>early</u> liver disease?	(iii) ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
10.	Please describe the severity of the illness	
(i)	Is there any jaundice?	(i) ☐ No ☐ Yes
(ii)	Duration of jaundice	(ii) From ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) Till ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)
(iii)	Is the jaundice deepening / worsening?	(iii) ☐ No ☐ Yes
(iv)	Is the jaundice likely to be permanent?	(iv) ☐ No ☐ Yes
(v)	Is there hepatic encephalopathy?	(v) ☐ No ☐ Yes
(vi)	Please give details of signs & symptoms of hepatic encephalopathy existing at present:	(vi) _____ _____
(vii)	Is there ascites?	(vii) ☐ No ☐ Yes
(viii)	Is the size of the liver rapidly decreasing?	(viii) ☐ No ☐ Yes
(ix)	Is there necrosis of entire liver lobules?	(ix) ☐ No ☐ Yes
(x)	Is there deterioration of liver function tests?	(x) ☐ No ☐ Yes

11. If report is not available, please state detailed results and dates below:

Tests	Date: _____	Date: _____	Date: _____	Date: _____
Albumin				
Total Bilirubin				
AST (SGOT)				
ALT (SGPT)				
Gamma GT (GGT)				
Alkaline phosphatase				
Ultrasound liver				
Others				

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TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST	
Signature and Official Stamp Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)	Name : _____ Address : _____ _____ _____

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