PT Great Eastern Life Indonesia
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Great Eastern
A member of the OCBC Group

EAR PROBLEM QUESTIONNAIRE (To be completed by the Medical Examiner)
KUESIONER GANGGUAN TELINGA (*Untuk diisi oleh Pemeriksa Kesehatan)*

Proposal Number / *Nomor SPAJ* :_____

Name / *Nama Calon Tertanggung* :_____

New NRIC No / *Nomor Identitas Diri* :_____

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1. What is the diagnosis? / *Apakah diagnosisnya?*

   _____

   _____

2. Date of diagnosis of the ear problem? / *Tanggal diagnosis gangguan telinga tersebut?*

   _____

   _____

3. Cause of the ear problem / *Penyebab gangguan telinga:*

   Congenital / *Sejak lahir* [ ] Elaborate / *Jelaskan:*

   _____

   Acquired / *Kejadian* [ ] Elaborate / *Jelaskan:*

   _____

4. What is the degree of hearing impairment? / *Apa tingkatan dari gangguan pendengaran tersebut?*

   _____

   _____

5. Is the ear problem / *Apakah gangguan telinga tersebut :-*

   Unilateral / Unilateral [ ]
   Bilateral / *Bilateral* [ ]

6. Its severity / *Tingkat Keparahan* :-
   Mild / *Ringan* [ ]
   Moderate / *Sedikit parah* [ ]
   Severe / *Parah* [ ]
   Acute / *Akut* [ ]
   Chronic / *Kronis* [ ]

7. Any associated impairments of / *Adakah Kerusakan yang terkait dengan* :-

	Yes / *Ya*	No / *Tidak*
- Cardiovascular System / *Sistem Kardiovaskular*	[ ]	[ ]
- Tumour / *Tumor*	[ ]	[ ]
- Syphilis / *Syphilis*	[ ]	[ ]

8. Complications / *Komplikasi* :

	Yes / *Ya*	No / *Tidak*
- Purulent ear discharge / *Lelehan bernanah di telinga*	[ ]	[ ]
- Meningitis	[ ]	[ ]
- Brain ulcers / *Ulser di otak*	[ ]	[ ]
- Lateral Sinus Thrombosis / *Trombosis sinus lateral*	[ ]	[ ]

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9. Treatment / *Perawatan* :

- Conservatif / *Konservatif* :

Date/*Tanggal*	**Drugs/*Obat***	**Dosage/*Dosis***	**Duration/*Jangka Waktu***

- Surgical / *Pembedahan* :

Date/*Tanggal*	**Type / *Jenis***	**Results / *Hasil***

10. Has he/she fully recovered? / *Apakah Tertanggung sudah pulih sepenuhnya*?

_____

_____

Signature of Medical Examiner / : _____ Date / *Tanggal* : _____
Tandatangan Pemeriksa Kesehatan

Name / *Nama* : _____ Clinic Stamp / *Stempel klinik* : _____