CROIX BLEUE MD DU QUÉBEC

Questionnaire

High Blood Pressure

IDENTIFICATION

Last name:	First name:
Contract Nᴼ:	Date of birth: M M D D Y Y Y Y

INFORMATION

1. Date of diagnosis: M M D D Y Y Y Y

2. Is there any history or current evidence of the following conditions? If yes, please provide details.

Cardiac impairment	☐ Yes	☐ No	___
Renal impairment	☐ Yes	☐ No	___
Retinopathy	☐ Yes	☐ No	___
ECG abnormality	☐ Yes	☐ No	___
X-Ray abnormality	☐ Yes	☐ No	___
Adverse blood chemistry	☐ Yes	☐ No	___

3. Type of treatment prescribed (medication, diet, etc.) : ___

   Date the treatment began: M M D D Y Y Y Y Name of medication(s) and dosage: ___

   ___

4. Please provide blood pressure reading after treatment:

   Systolic / Diastolic: ___ Date: M M D D Y Y Y Y

5. Ongoing treatment? ☐ Yes ☐ No

   If yes, please provide details: ___

6. Date of next follow-up visit: M M D D Y Y Y Y

7. Name and address of attending physician: ___

   ___

DECLARATION

I hereby declare that the above information is complete, accurate and current. I agree that this information will be used as the basis of the assessment carried out in order to establish my eligibility for Canassurance Hospital Service Association and/or Canassurance Insurance Company coverage. I also understand that, once my application has been assessed and approved, the information contained in this form will be an integral part of the insurance policy that will be issued. Any false statements in this form will lead to legal measures, including policy cancellation.

___ M M D D Y Y Y Y

Signature of the Insured Date

___ M M D D Y Y Y Y

Signature of policy holder (if different from Insured) Date

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