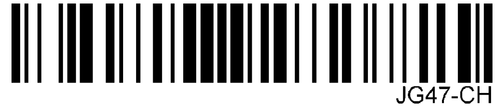
Chambers of Commerce
Group Insurance Plan®



HYPERTENSION QUESTIONNAIRE

Name ______________________________ Firm # ______________

Date of Birth (YYYY/MM/DD) ______________________________ Certificate # ______________

1. Have you ever been told that your blood pressure was high? ❑ Yes ❑ No
   If so, on what date was hypertension (high blood pressure) first noted? ______________________________
   ____

2. Do you presently have hypertension? ❑ Yes ❑ No

3. Have you ever had to stop working because of hypertension? ❑ Yes ❑ No If **Yes**, please specify dates
   From ______________ To ______________

4. Name and address of physician(s) consulted ______________________________
   ____

5. Name and address of hospital (if you were ever hospitalized) ______________________________
   ____

6. Type of medication prescribed ______________________________
   Daily Dosage ______________________________
   Date treatment started ______________________________
   Date treatment ended, if applicable ______________________________
   Reason for stopping treatment, if applicable ______________________________

7. Blood pressure readings

	SYSTOLIC	**DIASTOLIC**
The highest before first treatment	______	______
Average during treatment	______	______
At the time you stopped taking your medication (if applicable)	______	______

8. Date of last consultation and pressure readings at that time ______________________________
9. Have you ever been diagnosed with heart disease? ❑ Yes ❑ No ______________________________
   If **Yes**, what was the diagnosis, the date, the treatment received and name of the cardiologist if applicable ______________
   ____

I declare that the above information is true and complete and shall form part of my application for insurance.

______________________ ______________________________
Date Signature of Employee/Applicant

March2015