

PERSONAL BACKGROUND -- Do you have or have you ever been diagnosed with any of the following diseases?

J - Endocrine Diseases? YES NO If Yes, which::
 Thyroid Disease (1) Hypophyseal Tumour (1) Diabetes Mellitus Type 2 Other (_____)
 Adrenal Disease (1) Diabetes Mellitus Type 1 Nervous Anorexia (1)

K - Metabolic Disorders? YES NO If Yes, which:
 Increased Cholesterol Increased Triglycerides Increased Uric Acid (Gout) Other (_____)

L - Eye Diseases? YES NO If Yes, which:
 Impaired Visual Acuity / Use of Graduated Spectacles or Contact Lenses (Myopia, Astigmatism, Hyperopia) Glaucoma
 Strabismus Cataract Retinal Diseases Other (_____)

M - Ear, Nose and Throat Diseases? YES NO If Yes, which:
 Impaired Hearing / Use of Hearing Aids Recurring Tonsillitis and Adenoiditis Dizziness
 Recurring or Chronic Otitis Sinusitis Nasal Septum Deviation Other (_____)

N - Gynaecological Disorders? YES NO If Yes, which:
 Benign Breast Nodes Uterine Tumour (Benign) (1) Endometriosis Other (_____)
 Adnexal Tumour (Benign) (1) Uterine Prolapse Female Infertility

O - Infectious Diseases? YES NO If Yes, which:
 HIV or AIDS Carrier (1) Syphilis (1)
 Tuberculosis of the Lymphatic Glands, Kidney or another Organ (1) Other (_____)

P - Neoplasias? YES NO If Yes, which:
 Lung (1) Stomach (1) Prostate (1) Breast (1) Thyroid (1)
 Uterus (1) Colon (1) Kidney (1) Skin (1) Other (_____)

Q - Congenital Diseases? YES NO If Yes, which:
 Cardiac Renal Pulmonary Digestive Neurological
 Other (_____)
 If you have marked any disease up to this point, please indicate: _____
 Describe the clinical situation: _____

Clarifications / Further information

(1) In points "A, B, C, D, E, F, H, I, J, N, O and P", for diseases marked with (1), please indicate:
 Year of appearance: _____ Duration: _____ Examinations performed and treatment: _____
 Describe the situation: _____

(2) If you have marked the option "Fractures", in point "F", please indicate:
 Location of the fracture: _____ Treatment: _____
 _____ Sequels: _____

(3) If you have marked the option "Cranial or Spinal Cord Trauma", in point "H", please indicate:
 If you have neurological sequels: _____

If you have marked "Other", please indicate:
 Which: _____ Year of appearance: _____ Duration: _____ Examinations performed and treatment: _____
 Describe the situation: _____

FAMILY BACKGROUND

Have any of your Parents or Siblings already died? Yes No If Yes, which:
 Father Mother Sibling Age(s) _____
 Specify the cause(s): _____
 Does anyone in your Family suffer from a Serious and/or Chronic Disease? Yes No If Yes, which: _____

Date and Signatures

_____, ____/____/____ (Location and Date) _____ (Insured Person)

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