

CARDIOLOGY MEDICAL QUESTIONNAIRE

Call: +49 2303 9409904 Website: hcigroupglobal.com
Email: enquiries@healthcareinternational.com



Applicant Name

Date of Birth
D D M M Y Y

Do you smoke or use tobacco products? ☐ YES ☐ NO

YOUR MEDICAL CONDITION

1 - Have you ever had symptoms or been diagnosed with any type of heart disorder or cardiovascular disease? ☐ YES ☐ NO

If yes, please provide details in the table below

Medical Condition	Date of Onset	Treatment Carried Out	Current Status
Angina: unstable angina can be undiagnosed chest pain or a sudden worsening of existing angina.			
Heart Attack			
Cardiomyopathy			
Coronary Artery Disease			
Heart infections			
Arrhythmia / abnormal heart rhythms or pulse			

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Medical Condition	Date of Onset	Treatment Carried Out	Current Status
Abnormal EKG (electrocardiogram)			
Ventricular Fibrillation or flutter			
Valve disease and / or other arrhythmia disorder			
Peripheral artery disease			
High blood pressure			
Heart murmur			
Congenital heart conditions			
Inherited heart conditions			
Stroke/TIA			

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2 - Have any of the following tests been completed?

If yes, please provide details in the table below

☐

YES

☐

NO

Test Name	Date	Results
Thalium stress ECG		
Stress echocardiogram		
Coronary angiography		
Echocardiogram		
Chest x-ray		
Other tests not listed here (please populate)		

3 - Do you exercise on a regular basis?

☐

YES

☐

NO

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4 - Have you ever been diagnosed with any of the following?

Medical Condition	Y/N	Details
Abnormal lipid levels		
Elevated homocysteine		
Diabetes		
High blood pressure		
Peripheral Vascular Disease		
Irregular heartbeat		
Cancer		
Overweight		
Elevated cholesterol		
Date of last cholesterol test		
HDL/total cholesterol ratio		
Cerebrovascular or carotid disease		

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YOUR DECLARATION

I certify that these answers and statements are true to the best of my knowledge and belief. I will inform HealthCare International Europe GmbH of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree this document shall form a part of my request for coverage

Signature

Date

NEXT STEPS

Please check you've completed the entire form, then email it to us at enquiries@healthcareinternational.com

Remember to attach all supporting documents.