





10. Please provide details of treatment administered.

11. Please provide the names and addresses of all clinics/hospitals to which the patient has been referred to or attended for this condition together with the names of the doctors consulted.

**C. MEDICAL HISTORY**

12. Has the patient previously suffered from this or any related illness?  Yes  No  
If yes, please give dates of consultations, the resulting diagnosis, the name and address of attending doctor and source of information.

13. Is there anything in the patient's medical history which would have increased the risk of Aplastic Anaemia?  Yes  No  
If yes, please provide full details including the date of diagnosis, name and address of attending doctor and source of information.

13. Please give details of the patient's family history which would have increased the risk of Aplastic Anaemia (including the relationship, nature of illness, date of diagnosis and source of information).

14. Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

15. Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.

16. Does the patient have or ever had any other significant health condition(s)?  Yes  No  
If yes, please provide details of the condition, including diagnosis, date of diagnosis, duration of condition(s) and treatment received.

**D. ADDITIONAL INFORMATION**

17. Please provide us with any other additional information that will enable the Company to assess this claim.

**Signature of Doctor**

**Date**

**Name and Qualification (printed)**

**Address & Official Stamp**