

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.

12. Did Parkinson's Disease result from treatment for any other illness, or is it associated with any other disease, e.g. Wilson's Disease or Huntington's Chorea? Yes No
If yes, please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.

13. Is the Parkinson's Disease due to drug-induced or toxic causes? Yes No
If yes, please give details.

14. Can the condition be controlled with medication? Yes No
If yes, please give details.

15. Are there signs of progressive impairment? Yes No
If yes, please give details.

16. Given the ADL definitions stated below, please confirm which of the following patient is able/unable to undertake:

(a) **Washing**

Is the patient able to:

Bath? Yes No

Shower? Yes No

Wash satisfactorily by other means? Yes No

Please state _____

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(b) **Dressing**

Is the patient able to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances? Yes No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(c) **Transferring**

Is the patient able to move from a bed to an upright chair or wheelchair and vice versa? Yes No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(d) **Mobility**

Is the patient able to move indoors from room to room on level surfaces? Yes No

If no, please state why, how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(e) **Toileting**

Is the patient able to:

Use the lavatory? Yes No

Manage bowel and bladder functions? Yes No

Maintain a satisfactory level of personal hygiene? Yes No

If no, please state why (reason for the patient's restriction), how much assistance is required, on what date the patient became unable to perform these tasks and its duration.

(f) **Feeding**

Is the patient able to feed oneself once food has been prepared and made available? Yes No

If no, please state why and give details of the underlying problems, the amount of assistance required, on what date the patient became unable to perform these tasks and its duration.

C. MEDICAL HISTORY

17. Has the patient previously suffered from the condition specified above or any related illness? Yes No
If yes, please give date of diagnosis, their resulting diagnosis, the name and address of attending doctor and source of information.

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

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

20. 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.

21. 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.

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

D. ADDITIONAL INFORMATION

23. 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**