

- (r) Please give details of the patient's history and present habits pertaining to alcohol consumption, cigarette smoking and drug addiction.

3. MEDICAL HISTORY

- (a) If the patient was referred from a clinic or hospital, please state:

- (i) Name of referral doctor: _____
(ii) Name of clinic/ hospital: _____
(iii) Date referred: _____

- (b) Did the patient consult other doctors for this condition before she consulted you? Yes No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

- (c) Is the patient suffering or has suffered from any other significant illnesses? Yes No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

- (d) Please provide us with any other additional information that will enable the Company to assess this claim.

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Name and Qualification (printed)

Address & Official Stamp