

(k) Is the prostate the primary site of origin? Yes No

If no, please state the primary site of origin.

(l) Type of surgery performed: _____

(m) Date of surgery: ____/____/____
 dd mm yyyy

(n) Name and address of Hospital: _____

(o) Name and address of the Doctor who performed the surgery.

(p) Please give full details of all investigations performed in relation to this condition and their results.

(q) Please give details of the patient's habits in relation to alcohol, cigarette smoking and drug addiction, both past and present.

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 illness or its symptoms before he/ she consulted you?

Yes No

If yes, please provide the name(s) and address(es) of the doctor(s) whom he/ 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) Did you refer the patient to any other doctor(s)? Yes No

If yes, please provide the name and address of the doctor(s).

(e) Please give any other information which you feel would be helpful in assessment of the patient's 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