FUTURE GENERALI
TOTAL INSURANCE SOLUTIONS

MENTAL HEALTH CONDITIONS QUESTIONNAIRE - PHYSICIAN

TO BE FILLED BY THE PHYSICIAN

Name of the Life Insured

Application Number

PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED

1. Please state the diagnosis of the disorder: _____
2. When did the symptoms first occur? _____
3. What were the presenting symptoms? _____
4. How many times has the patient visited you in the last 12 months? _____
5. Please describe any precipitating factors that may have caused or exacerbated the patient's symptoms: _____

   _____
6. Has there been more than one episode? ☐ Yes ☐ No
7. Please advise the date and duration of each episode:
8. Has the patient now fully recovered? ☐ Yes ☐ No
   i. If 'Yes', please advise since when: _____
   ii. If 'No', please provide full details of any residual symptoms: _____
   iii. Are the patient's work, social and domestic situations now stable? ☐ Yes ☐ No
   iv. If 'No', please provide details: _____
9. Have there been any suicidal thoughts, tendencies or actual suicide attempts? If 'Yes', please give full details, including the dates:

   _____
10. Please advise on time taken off-work due to the mental health condition(s) (i.e. duration, reason): _____
11. Please give details of the treatment:
    i. Current medication, including name and dosage: _____
    ii. Past medication, including name and dosage: _____
    iii. Any ECT or Lithium treatment, including dates: _____
    iv. Any specialist/psychiatric referral, including name of the specialist, nature of the referral, and dates: _____
    v. Any in-patient therapy (hospitalization), including reason and dates: _____
12. Please comment on any other relevant features, that may influence the prognosis of the disease, such as any history of alcohol or substance abuse, co-existing physical illness and/or behavioural abnormalities, current weight, etc.

    _____

    _____

I hereby declare, that the above answers and statements are true and complete, and agree, that this together with the proposal dated _____ shall form part of the contract between my patient and the company.

Place: _____ Date: _____

_____
Signature of the Life Insured

Name of the Physician: _____

Signature of the Physician:

Please print your name and add clinic's stamp.