



## Diagnosis

1. When was your high blood pressure (hypertension) diagnosed?
2. Why was your blood pressure measured at that time? (for example, routine exam, due to symptoms, pregnancy, executive health check, check due to family history, life assurance medical or other?)

3. Have you ever had any tests or investigations carried out in connection with this condition? Yes  No   
 (examples include blood tests, ECG, echocardiogram, 24-hour blood-pressure monitor, urine tests, exercise or treadmill stress test, coronary angiogram). If 'Yes', please give dates and results.

Date:

Test:

Result:










4. Do any of your immediate family (mother, father, brothers, sisters) suffer from or had any of the following before age 60 – raised blood pressure, raised cholesterol, angina, heart attack, heart disease, bypass surgery, angioplasty, stroke or diabetes? Yes  No

If 'Yes', please list all those affected, the condition suffered and their age at diagnosis.

Relative	Condition	Age when diagnosed

## Symptoms

5. Have you had any symptoms (for example dizziness, headache, chest pain, other)? Yes  No   
 If 'Yes', please give full details including dates.

Date:

Nature of problem:







6. Do you have any related medical conditions? Yes  No   
 (for example, raised cholesterol, raised blood-sugar levels, diabetes, kidney problems, chest pain, problems with your eyes etc)? If 'Yes', please give details.

7. Do you smoke tobacco or have you ever smoked? Yes  No

If 'Yes', please give full details including the year you started smoking, the year you stopped (if this applies) and how much tobacco you smoke each day.

Year you started smoking:

Year you stopped smoking (if this applies).



How much tobacco do you currently smoke or used to smoke if you have now stopped?

(number of cigarettes, cigars or ounces of tobacco)?	cigarettes	per day
	cigars	per day
	ounces of tobacco	per day

## Treatment

8. Do you currently take medication or other treatment for this condition? Yes  No

(for example, Adalat, Atenolol, Capoten, Centyl K, Innovace, Zestril, Omesar or other)?

If 'Yes', please give name(s) and dosage each day.

Name(s):

  
  

Dosage each day:

  
  

- Have you ever stopped taking your medication(s)? If 'Yes', why? Yes  No

9. Has the type of medication or dosage been changed since you began treatment? Yes  No

If 'Yes', please give dates and details of the changes.

Date:

  

Changes made:

  

Reason:

  

10. Have any future treatments or investigations been discussed? Yes  No

(such as changing your medication, referral to a specialist doctor, surgery or other therapy)?

If 'Yes', please give details.

11. Have you ever been treated in hospital for this or any other heart condition? Yes  No

If 'Yes', was it:

Inpatient?

Yes  No

Date

Details and how long you stayed

  

Outpatient?

Yes  No

Date

Details and why

  

Accident and emergency?

Yes  No

Date

Details and why

12. About monitoring your condition

Who do you see to review your condition?

How often do you go for a review?

What has your doctor (and specialist, if you have one), told you about your current blood-pressure control?

When was your last consultation? Date

Please provide details of your last blood-pressure reading if you know.

Do not know  (tick if appropriate)

Date:  Reading:

If you were told that your blood pressure was completely normal at that time, please say this

13. Please provide any other information on this subject which you feel may be beneficial in assessing your application.

Please, outline details of any regular exercise you undertake or lifestyle changes your doctor has recommended, or you yourself have implemented as a result of your condition (for example, weight reduction, low-salt diet or other).

### Declaration

Please review the answers given in this questionnaire and then read, sign and date this declaration.

I agree that this questionnaire will form part of my application for cover to Irish Life Assurance plc.

I have read and understood the note on the first page of this form about telling Irish Life about material facts and I understand that if I do not reveal all these facts, Irish Life could treat the plan as void and in these circumstances Irish Life will not pay a claim or refund my payments.

I have read over the answers to all the questions on this form and declare that all statements (including any statements written down for me) are true and complete. I understand a copy of this form is available to me if I ask.

I understand that this cover will not start until you have accepted me for cover and I have paid the first premium.

I understand that I must tell you in writing about any changes in my personal medical circumstances, family history or taking part in dangerous pursuits before this cover is accepted.



Please sign and date

Signature

Date

In the interest of customer service we will record and monitor calls.

Irish Life Assurance plc is registered in Ireland number 152576, VAT number 9F55923G.