

## Additional questionnaire

as a supplement to the application resp. demand for an offer from: \_\_\_\_\_

(does not replace answering the health questions in the application resp. demand for an offer)

## Kidney and urinary tract diseases

**Incorrect or incomplete information may entitle us - depending on fault - to withdraw from the contract, to terminate it or to adjust it, which can lead to the insurer being released from performance - even for insured events that have already occurred. Please also note the “Information of the Consequences of the Violation of the Disclosure Obligation” in the application.**

**We ask you not to send us any results or data of genetic examinations or analysis!  
You only have to inform us of already existing complaints, pre-existing conditions, no matter by which examination methods you have acquired this information.**

What was the medical doctor's diagnosis for the disease?

- |  |   |
|--|---|
| <input type="checkbox"/> inflammation of the bladder (cystitis)  | <input type="checkbox"/> inflammation of the urethra (urethritis) |
| <input type="checkbox"/> inflammation of the ureter (ureteritis) | <input type="checkbox"/> inflammation of kidney pelvis (pyelitis) |
| <input type="checkbox"/> kidney inflammation                     | <input type="checkbox"/> kidney stones                            |
| <input type="checkbox"/> urinary bladder stones                  | <input type="checkbox"/> urethral stone                           |
| <input type="checkbox"/> ureteral stones                         | <input type="checkbox"/> floating kidney (nephroptosis)           |
| <input type="checkbox"/> shrinking kidney                        | <input type="checkbox"/> stasis kidney                            |
| <input type="checkbox"/> urinary incontinence                    | <input type="checkbox"/> renal insufficiency (renal failure)      |
| <input type="checkbox"/> others, which ones?                     |   |

What complaints have you had, or do you have?

- |  |   |
|--|---|
| <input type="checkbox"/> frequent urination      | <input type="checkbox"/> urge to urinate            |
| <input type="checkbox"/> nocturnal urination     | <input type="checkbox"/> involuntary urine leakage  |
| <input type="checkbox"/> urinary retention       | <input type="checkbox"/> pain during urination      |
| <input type="checkbox"/> weakened urinary stream | <input type="checkbox"/> delayed start of urination |
| <input type="checkbox"/> others, which ones?     | <input type="checkbox"/> blood in urine (hematuria) |
- 

When do or did the complaints occur?

first occurrence? \_\_\_\_\_ last occurrence? \_\_\_\_\_

How often do the complaints occur on average?

\_\_\_\_\_ per day      \_\_\_\_\_ per month      \_\_\_\_\_ per year

Does one of the following diseases/disorders exist?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> cysts                        | <input type="checkbox"/> single kidney     | <input type="checkbox"/> double kidney     |
| <input type="checkbox"/> urinary outflow obstructions | <input type="checkbox"/> renal dysfunction | <input type="checkbox"/> none of the above |

How often did the disease occur?

- |                                       |             |           |                  |
|---------------------------------------|-------------|-----------|------------------|
| <input type="checkbox"/> one-time     | from: _____ | to: _____ |                  |
| <input type="checkbox"/> repeatedly   | from: _____ | to: _____ | when/last: _____ |
| <input type="checkbox"/> continuously | from: _____ | to: _____ |                  |

What is the course of the disease?

- acute     chronic

What examinations have been performed so far or are recommended?

- ultrasonic examination (sonography) when? \_\_\_\_\_
  - urography (contrast X-ray) when? \_\_\_\_\_
  - laboratory examination when? \_\_\_\_\_
  - others, which ones? when? \_\_\_\_\_
- 

Findings, examination results?

---

**Please provide us with a copy of the treatment and findings reports!**

What treatment methods/therapies have been performed so far or are recommended?

- medication therapy (drug therapy), name? - dosage? from - to? \_\_\_\_\_
  - operation/surgery, which one? when? \_\_\_\_\_
  - others, which ones? from - to? \_\_\_\_\_
- 

Is there/ was there a stone disease?

yes  no

Are the kidney stones or kidney semolina still present?

yes  no

If "no", way of removal?

- operation, surgery when? \_\_\_\_\_
  - kidney stone fragmentation (lithotripsy) when? \_\_\_\_\_
  - medications (drugs) when? \_\_\_\_\_
  - natural kidney stone discharge when? \_\_\_\_\_
  - others, which ones? when? \_\_\_\_\_
-

Is a stone prophylaxis performed?

yes  no

What is the cause or underlying disease?

- |  |  |
|--|--|
| <input type="checkbox"/> malformation            | <input type="checkbox"/> tumor                                     |
| <input type="checkbox"/> stones                  | <input type="checkbox"/> infections (e.g. streptococcal infection) |
| <input type="checkbox"/> injury through accident | <input type="checkbox"/> toxic influences                          |
| <input type="checkbox"/> collagen disease        | <input type="checkbox"/> autoimmunological mechanisms              |
| <input type="checkbox"/> other, which ones?      | <input type="checkbox"/> allergic reaction                         |

---

Are both kidneys completely functional?

yes  no

**Single kidney:**

Has the remaining kidney taken over the full function?

yes  no

**Please submit findings with current creatinine and urine values**

Are there any secondary diseases such as renal hypertension?

yes  no

If "yes", which ones?

---

Are control examinations still necessary?

yes  no

If "yes", how often?

\_\_\_\_\_ per year

When was your last treatment?

when/last? \_\_\_\_\_

Are further diagnostic and/or therapeutic measures necessary, intended or recommended?

yes  no

If "yes", which ones?

---

