

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)

High blood pressure/ Hypertension

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"/> arterial hypertension | <input type="checkbox"/> systolic hypertension |
| <input type="checkbox"/> renal hypertension | <input type="checkbox"/> threshold hypertension |
| <input type="checkbox"/> high blood pressure, hypertension | <input type="checkbox"/> white coat hypertension |
| <input type="checkbox"/> others, which ones? | |

Are there or have there been any diseases of the heart?

☐ yes ☐ no

If “yes”, which ones?

- | | |
|---|--|
| <input type="checkbox"/> circulatory disorder of the coronary vessels | <input type="checkbox"/> heart infarction, myocardial infarction |
| <input type="checkbox"/> angina pectoris | <input type="checkbox"/> cardiac enlargement, cardiomegaly |
| <input type="checkbox"/> others, which ones? | |

What form of hypertension is it?

- | | |
|--|--|
| <input type="checkbox"/> kidney related (renal) | <input type="checkbox"/> hormonal related (endocrine) |
| <input type="checkbox"/> aortic isthmus stenosis
(coarctation of the aorta) | <input type="checkbox"/> without known cause (essential) |
| <input type="checkbox"/> other cause, which ones? | |
-

When was hypertension first diagnosed?

Did you have any complaints/symptoms?

☐ yes ☐ no

If "yes", which ones?

- | | |
|--|--|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> racing heart |
| <input type="checkbox"/> cardiopalmus (heart palpitations) | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> heart pain | <input type="checkbox"/> feeling disorders in arms or legs |
| <input type="checkbox"/> others, which ones? | |
-

When did the complaints first occur?

When did the complaints last occur?

What examinations have been performed so far or are recommended?

- | | | |
|--|-------------|------------------|
| <input type="checkbox"/> ECG (electrocardiography), ergometry | when? _____ | how often? _____ |
| <input type="checkbox"/> computer tomography (CT scan) or
magnetic resonance tomography | when? _____ | how often? _____ |
| <input type="checkbox"/> cardiac catheterization | when? _____ | how often? _____ |
| <input type="checkbox"/> sonography, ultrasonic examination | when? _____ | how often? _____ |
| <input type="checkbox"/> Doppler or colour Doppler examination | when? _____ | how often? _____ |
| <input type="checkbox"/> long-term blood pressure reading | when? _____ | how often? _____ |
| <input type="checkbox"/> laboratory examinations | when? _____ | how often? _____ |
| <input type="checkbox"/> others, which ones? | when? _____ | how often? _____ |
-

Findings/ examination results?

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

When was blood pressure last recorded? _____ ☐ self-measured
☐ Doctor measured

With which result (at rest)? systolic.: _____ diastolic.: _____

Are the above-mentioned blood pressure values under medication? ☐ yes ☐ no

Are you taking medication for high blood pressure? ☐ yes ☐ no

If “yes”, name? - dosage?

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

☐ medication therapy (drug therapy) from - to? _____

☐ inpatient treatment from - to? _____

☐ spa treatment, cure from - to? _____

Have there already been consequential damages (e.g. vascular constriction, cardiac enlargement/ cardiomegaly, retinal damages or kidney damages)? ☐ yes ☐ no

If “yes”, what consequential damages do you have?

Are there other risk factors that affect the prognosis of cardiovascular disease? ☐ yes ☐ no

If “yes”, which ones?

☐ diabetes mellitus ☐ hypercholesterolemia

☐ hypertriglyceridemia ☐ hyperuricemia (increased uric acid)

☐ others, which ones? ☐ overweight

nicotine (quantity)? _____

alcohol (quantity)? _____

When were you last in treatment? _____

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

☐ yes ☐ no

If “yes”, which ones?

Are you free of treatments and complaints?

☐ yes ☐ no

If “yes”, since when?

If “no”, which complaints do you have?

Which doctor can provide information? (Please provide name and address.)

Additional comments from the applicant or interested party:

Notice: Please let us have the discharge, examination, treatment and findings reports available to you for a short time (if possible, a copy).

Declaration

The information provided on the questions has been answered correctly and completely to the best of our knowledge. I am solely responsible for the correctness of the information, even if I did not fill out the declaration myself. I have observed the information on the “Consequences of the Violation of the Disclosure Obligation” in the application.

Place/date

Signature of the applicant resp. interested party