Manulife

ANXIETY / DEPRESSION / NERVOUS DISORDER / MENTAL ILLNESS QUESTIONNAIRE
(TO BE COMPLETED BY ATTENDING PHYSICIAN)

Policy No. : _____

Name of Life Insured : _____ **NRIC NO. :** _____

1. What was the diagnosis of the condition?

_____

2. Please advise:

i) Date symptoms first commenced

_____

ii) Date patient first presented with symptoms (please advise if you are aware of any prior consultations with other practitioners)

_____

iii) Does the patient still suffer from symptoms? ☐ **Yes** ☐ **No**
Please give date last symptoms experienced

_____

3. What were the presenting symptoms?

_____

4. Did the condition develop as a reaction to particular circumstances? ☐ **Yes** ☐ **No**

If "yes" please describe circumstances.

_____

5. Have there been any suicidal ideation or actual suicide attempts? ☐ **Yes** ☐ **No**

If "yes" please give full details including dates.

_____

6. Were there any symptoms of a psychosomatic nature eg palpitations, chest pain, IBS, dyspepsia, migraine, etc? ☐ **Yes** ☐ **No**

If "yes" please provide details including dates, results of investigations and treatment.

_____

7. Please advise:

i) Has medication ever been prescribed? ☐ **Yes** ☐ **No**

If "yes" advise type and dosage.

_____

ii) Is the patient still taking medication? ☐ **Yes** ☐ **No**

If "yes" advise type and dosage.

iii) Is the patient receiving any other ongoing therapy in relation to this condition? ☐ **Yes** ☐ **No**

If "yes please advise.

_____

iv) Has electroconvulsive therapy ever been necessary? ☐ **Yes** ☐ **No**

If "yes" advise dates and number of treatments.

_____

v) Has the patient ever required hospitalisation? ☐ **Yes** ☐ **No**

If "yes" advise dates, duration and name of hospital.

_____

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Manulife Insurance Berhad Registration No. 200801013654 (814942-M)
(Licensed under the Financial Services Act 2013 and Regulated by Bank Negara Malaysia)
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8. **Has your patient ever been referred to a psychiatrist, psychologist, counsellor or any other therapist?** ☐ Yes ☐ No

If "yes" please advise dates, names and addresses (a copy of any specialist reports in your possession would be appreciated)

_____

9. **Has the patient ever been off work or has normal daily activities been restricted in any way due to this condition?** ☐ Yes ☐ No

If "yes" please advise details including when and for how long.

_____

10. **Is the patient now able to perform his/her usual occupation and normal daily activities without restriction?** ☐ Yes ☐ No

If "no" please give details.

_____

This report has been prepared by:

_____ _____

Signature of Doctor **Clinic Rubber Stamp**

Name : _____

Telephone No. : _____

Dated : _____

Kindly return this Questionnaire in a sealed envelope to the underwriter of our Company so as to maintain confidentiality of the information provided.

We thank you for completing this questionnaire