PhilCare
Healthcare Made Smarter

MEDICAL QUESTIONNAIRE : Answer all the following questions in the appropriate check box provided below. If you are applying for a family coverage, all questions are applicable to each applicant. Use the space provided below to give full details of items with "YES" answers.*

USE ADDITIONAL SHEET IF NECESSARY

NAME OF APPLICANT

	Applicant 1		Applicant 2		Applicant 3	
Check Box						
1. Have you ever had a history of, and/or treatment, consultation or known indication for:	YES	NO	YES	NO	YES	NO
a. Disorder of eyes, nose, or throat ?	☐	☐	☐	☐	☐	☐
b. Dizziness, fainting, convulsion, headache, speech defect, paralysis or stroke, mental or nervous disorder ?	☐	☐	☐	☐	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood-spitting, tuberculosis, asthma or other chronic respiratory disorders ?	☐	☐	☐	☐	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels ?	☐	☐	☐	☐	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder ?	☐	☐	☐	☐	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs ?	☐	☐	☐	☐	☐	☐
g. Diabetes, thyroid or other endocrine disorder ?	☐	☐	☐	☐	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, such as spine, back or joints ?	☐	☐	☐	☐	☐	☐
i. Deformity, lameness or amputation ?	☐	☐	☐	☐	☐	☐
j. Disorder of skin, lymph glands, cysts, tumor or cancer ?	☐	☐	☐	☐	☐	☐
k. Allergies, anemia, or other disorder of the blood ?	☐	☐	☐	☐	☐	☐
l. Excessive use of alcohol, tobacco, or any habit forming drugs ?	☐	☐	☐	☐	☐	☐
2. Are you now under observation or taking treatment ?	☐	☐	☐	☐	☐	☐

NAME OF APPLICANT

	Applicant 1		Applicant 2		Applicant 3	
	YES	NO	YES	NO	YES	NO
3. Have you had any change in weight in the past years ?	☐	☐	☐	☐	☐	☐
4. Other than the above, have you:	☐	☐	☐	☐	☐	☐
a. Had any physical disorder or any known indication thereof ?						
b. Had a medical examination, consultation, illness, injury, or surgery ?	☐	☐	☐	☐	☐	☐
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility ?	☐	☐	☐	☐	☐	☐
d. Had electrocardiogram, x-ray, or other diagnostic tests ?	☐	☐	☐	☐	☐	☐
e. Been advised to have any diagnostic test, hospitalization or surgery which was not completed ?	☐	☐	☐	☐	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition ?	☐	☐	☐	☐	☐	☐
6. Have you ever applied for or received a pension payment, or benefit due to injury, sickness or disability ?	☐	☐	☐	☐	☐	☐
7. Have you a parent, brother or sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness ? If so, at what age ?	☐	☐	☐	☐	☐	☐
8. Do you or other members of the family smoke ?	☐	☐	☐	☐	☐	☐
a. If yes, since when ? How many sticks a day ?_____	☐	☐	☐	☐	☐	☐
b. If you have quit smoking, since when ? How long have you smoked ? How many sticks a day ? _____	☐	☐	☐	☐	☐	☐
9. FOR FEMALES ONLY						
a. Have you ever had any abnormal menstruation, pregnancy, childbirth, or disorder of the female organ or breasts ?	☐	☐	☐	☐	☐	☐
b. Are you now pregnant ? If yes, how many months ? _____						

** Use the space provided below to give full details of items with "YES" answers.*

NAME OF FAMILY MEMBER	DATE OF HISTORY TREATMENT, CONFINEMENT, ETC	CHIEF COMPLAINTS AND DIAGNOSIS	TREATMENT AND RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL

(Use additional sheet / form if necessary)

We hereby declare and agree that all statements and answers contained herein and in any addendum annexed to this application are full, complete and true and binds all parties in interest under the Health Care Coverage (the Agreement) herein applied for, that there shall be no contract of health care coverage unless and until an Agreement is issued on this application and the full Membership Fee according to the mode of payment is paid during the good health of proposed Member(s); that the health care coverage of any Member shalltake effect only on the Effective Date as indicated in the issued Agreement or the actual date full Membership Fee was paid, whichever is later; that no information acquired by any Representative of PhilCare shall be binding upon PhilCare unless set out in writing in this application; that any physician is, by these presents, expressly authorized to disclose or give testimony at anytime relative to any information acquired by him in his professional capacity upon any question affecting the eligibility, for health care coverage of the proposed Members and that the acceptance of any Agreement issued on this application shall be a ratification of any information on correction in addition to this application.
We hereby affirm that we have read and understood the contents of the health care contract as discussed in the attached Re-affirmation Letter. As proof of the foregoing, We are submitting a signed conforme of the same with this Application Form.

We hereby understand that we, the enrollees, will only start availing of the benefits of the program upon the effectivity of the policy.

SIGNED AT _____ THIS _____ DAY OF _____

_____ PRINTED NAME AND SIGNATURE OF WITNESS

_____ PRINTED NAME AND SIGNATURE OF PRINCIPAL APPLICANT

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

(The form below should be completed for each case)

I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____ to give to the PhilhealthCare, Inc. any and all information relative to any hospitalization, consultation, treatment, or any other medical advice or examination. This authorization is in connection with the application for health care coverage or with any benefit availed and with any claim for benefits under such coverage. A photographic copy of this authorization shall be as valid as the original.

_____ PRINTED NAME AND SIGNATURE OF WITNESS

_____ PRINTED NAME AND SIGNATURE OF PRINCIPAL APPLICANT

ARLEN O. MACASPAC- 9010000904132
PRINTED NAME AND SIGNATURE OF PARTNER AND CODE NO.

_____
APPLICATION NO.