



**MEDICAL QUESTIONNAIRE**

According to the General Conditions of the Travel Cover Plan article 8.1.1, we thank you to fill in the following questionnaire and to send it back to Golden Care Services.

Family Name : \_\_\_\_\_ First Name : \_\_\_\_\_

Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Weight (kg) : \_\_\_\_\_ Height (cm) : \_\_\_\_\_
2. Blood pressure :  normal If not, what is your blood pressure :
3. Are you in good health ? Yes  No
4. Have you consulted a physician or Have you already been hospitalised over the last 3 years ? Yes  No
5. Do you have any neo natal malformation / or any chronic / or any congenital disease ?  
Do you suffer from the sequels of any disease or accident ? Yes  No
6. Has already an abnormality been noticed in biological test? Yes  No
7. Was an affection of respiratory or cardiovascular organs found ? Yes  No
8. Are you presently under treatment / under medical control or taking any medicine ? Yes  No
9. Are you going to be surgically operated on or going to have any medical complementary examinations during the following months? Yes  No

**FOR WOMEN :**

10. Are you pregnant or do you think you are pregnant ? Yes  No
11. Have you suffered from any gynaecologic disease / breast cancer ? Yes  No

**MEDICAL DECLARATION (if you answer "Yes" to questions 4 to 11) :**

Question N°	Date of the Event	Diagnosis	Nature of treatment followed	Current Conditions	Future Treatments

Signature : \_\_\_\_\_ Place : \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/\_\_\_\_