GENERALI Central
LIFE INSURANCE

Mental Health Conditions Questionnaire - Physician

(To be filled by the Physician)

Name of the Life Insured			
Application Number		Branch	

1. Please state the diagnosis of the disorder: _____
2. When did the symptoms first occur? _____
3. What were the presenting symptoms? _____
4. How many times has the patient visited you in the last 12 months? _____
5. Please describe any precipitating factors that may have caused or exacerbated the patient's symptoms: _____

   _____
6. Has there been more than one episode? ☐ Yes ☐ No
7. Please advise the date and duration of each episode: _____
8. Has the patient now fully recovered? ☐ Yes ☐ No
   i. If 'Yes', please advise since when: _____
   ii. If 'No', please provide full details of any residual symptoms: _____
   iii. Are the patient's work, social and domestic situations now stable? ☐ Yes ☐ No
   iv. If 'No', please provide details: _____
9. Have there been any suicidal thoughts, tendencies or actual suicide attempts? If 'Yes', please give full details, including the dates:

   _____
10. Please advise on time taken off-work due to the mental health condition(s) (i.e. duration, reason): _____
11. Please give details of the treatment:
    i. Current medication, including name and dosage: _____
    ii. Past medication, including name and dosage: _____
    iii. Any ECT or Lithium treatment, including dates: _____
    iv. Any specialist/psychiatric referral, including name of the specialist, nature of the referral, and dates: _____
    v. Any in-patient therapy (hospitalization), including reason and dates: _____
12. Please comment on any other relevant features, that may influence the prognosis of the disease, such as any history of alcohol or substance abuse, co-existing physical illness and/or behavioural abnormalities, current weight, etc.

    _____

    _____

I hereby declare, that the above answers and statements are true and complete, and agree, that this together with the proposal dated _____ shall form part of the contract between my patient and the company.

Place: _____ Date: _____ _____

Signature of the Life Insured

Name of the Physician: _____

Signature of the Physician:

Please print your name and add clinic's stamp.