CMSM
Caisse Mutuelle Socio-Médicale
الصندوق التعاضدي الإجتماعي الصحي

# Unified Additional Questionnaire

## General Information

| | | |
|---|---|---|
| Name: | | Blood pressure: |
| Date of Birth: | | Pulse: |
| Height: | BMI: | Tobacco use: |
| Weight: | | Alcohol use: |

## Personal Medical History

| Disease / Surgery | Medication / Pathology | Start Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Family Medical History

Family history of chronic illness (Cancer, Cardiovascular, Diabetes, Depressive disorder.....)

| Disease Name | Family Member |
|---|---|
| | ☐Father ☐Mother ☐Uncle ☐Aunt ☐Grandparent |
| | ☐Father ☐Mother ☐Uncle ☐Aunt ☐Grandparent |
| | ☐Father ☐Mother ☐Uncle ☐Aunt ☐Grandparent |

## Physician's Information

I, the undersigned, Dr. ..... assert that the information provided above in this proposal, in respect of my patient, is complete, precise and true.

Date: .....

Signature & Stamp: .....

*This proposal form includes a medical questionnaire and constitutes the basis of the decision of CMSM to contract with the applicant mentioned hereunder or to refrain thereof. It also constitutes the basis of the terms, conditions, and exclusions of the Medical Program. Any concealment or misstatement may void the contract, pursuant to section 982 of the code of obligations.*


Address
Maronite Mutuality
HouseZouk Mosbeh,
Adonis

Telephone
+961 9 225 547
+961 3 425 742

Fax
+961 9 225 547
Ext. 210

Email
info@cmsm.org.lb

www.cmsm.org.lb