



Examinee's Statement of Medical and Personal History

N.B. — If any unfavourable feature is disclosed, it will be in the interest of the Examinee to give the fullest relevant information. Please obtain examinee's signature to the authorisation below, check and enter the identification document number below.

1. Name of Insured (Surname first) 受保人姓名		2. Date of Birth 出生日期 (DD日/MM月/YYYY年)					
3. <input type="checkbox"/> Mr 先生 <input type="checkbox"/> Mrs 太太 <input type="checkbox"/> Miss 小姐 <input type="checkbox"/> Ms 女士		4. HKID/Passport No. 香港身分證/護照號碼					
5. a. Reason and date of last consultation: 最近接受醫生診治之日期及原因: b. Name and address of your last attending doctor: 最近接受診治之醫生的姓名及地址:	6. Family history 家庭資料	Living 健在	Age 年齡	Health status 健康情況	Deceased 身故	Age 年齡	Cause of death 死因
	Father 父親						
	Mother 母親						
	Siblings 兄弟與姊妹						
So far as you know have you ever had or been treated for or been told you had any disease or disturbance of: 就閣下所知曾否患有以下疾病或機能失調及/或因此接受治療:						Yes 是	No 否
7. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, shortness of breath, poor circulation or other disorder of the heart? 胸痛、心悸、高血壓、風濕性熱、心雜音、心臟病發、呼吸困難、血液循環不良或其他心臟疾病?						<input type="checkbox"/>	<input type="checkbox"/>
8. Respiratory disorder, shortness of breath, blood spitting, persistent hoarseness or cough, bronchitis, pleurisy, asthma, emphysema or tuberculosis? 呼吸器官疾病、呼吸困難、吐血、持久沙啞或咳嗽、支氣管炎、胸膜炎、哮喘、肺氣腫或肺結核?						<input type="checkbox"/>	<input type="checkbox"/>
9. Jaundice, hepatitis, ulcer, colitis, gallstones, diverticulitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder? 黃膽病、肝炎、潰瘍、結腸炎、膽石、憩室炎、經常消化不良或其他胃、腸、肝或膽的疾病?						<input type="checkbox"/>	<input type="checkbox"/>
10. Sugar, albumin, blood or pus in urine, stone or other disorder of kidney, bladder, prostate or reproductive organs? 尿中有糖、蛋白、血或膿、腎、膀胱、前列腺或生殖器官結石或其他疾病?						<input type="checkbox"/>	<input type="checkbox"/>
11. Disorder of eye or ear, dizziness, convulsions, epilepsy, headaches, speech defect, paralysis or stroke; mental or nervous disorder? 眼或耳的疾病、暈眩、痙攣、癲癇、頭痛、語言缺陷、癱瘓或中風、精神病?						<input type="checkbox"/>	<input type="checkbox"/>
12. Diabetes, thyroid or other endocrine (glandular) disorders? 糖尿、甲狀腺或其他腺系統的疾病?						<input type="checkbox"/>	<input type="checkbox"/>
13. Deformity, lameness or amputation, disorder of the spine, back, neck, joints, muscles, bone, nerves including neuritis, sciatica, rheumatism, arthritis or gout? 畸形、跛或斷肢、脊椎骨、背部、頸、關節、肌肉、骨、神經系統的疾病包括神經炎、坐骨神經痛、風濕、關節炎或痛風?						<input type="checkbox"/>	<input type="checkbox"/>
14. Cancer, tumour, cyst or disorder of the skin or lymph gland? 癌症、腫瘤、囊腫或皮膚或淋巴腺的疾病?						<input type="checkbox"/>	<input type="checkbox"/>
15. Congenital disorder, allergies, anaemia, leukemia or other disorder of blood? 先天性的疾病、敏感、貧血、壞血病或其他血的疾病?						<input type="checkbox"/>	<input type="checkbox"/>
16. Alcoholism or drug abuse? 酗酒或濫用藥物?						<input type="checkbox"/>	<input type="checkbox"/>
17. Venereal disease, AIDS, AIDS-related complex or AIDS-related conditions? Have you had any blood test for the HIV virus? 性病、愛滋病、與愛滋病有關的併發症或狀況? 你曾否接受愛滋病毒病的測驗?						<input type="checkbox"/>	<input type="checkbox"/>
18. Autoimmune disorder, lupus erythematosus or rheumatoid arthritis? 免疫系統疾病、紅斑狼瘡或類風濕關節炎?						<input type="checkbox"/>	<input type="checkbox"/>
Within the past five years have you had any: 在過去五年內你曾否:							
19. (a) medical consultation, or (b) operations, hospital care, medical tests (including mammogram, pap smear, ultrasound or biopsies), X-ray, medical treatment or any other treatment or examination not mentioned above (exclude consultations for minor complaints, such as flu, cold, as well as pre-employment medical examination which did not lead to any further investigation or treatment)? (a) 就診或(b) 接受手術、入院療養、X光檢驗、內科治療、體格檢驗(包括乳X光、子宮頸細胞塗片檢驗、超聲波或活體檢視)或以上未提及的治療(普通病症如傷風、感冒及受聘前的健康檢查而不需要額外檢驗和治療者除外)?						<input type="checkbox"/>	<input type="checkbox"/>
20. Illness, operation, medical advice or hospital treatment not mentioned above? 患有上文並未提及的疾病、接受過手術、治療或需留院?						<input type="checkbox"/>	<input type="checkbox"/>
21. Pension and/or claimed payment for any sickness, accident or injury? 因疾病、意外或受傷而取得賠償或退休金?						<input type="checkbox"/>	<input type="checkbox"/>
22. Has your weight changed more than 10 lbs in the past year? 過去一年內, 體重曾否有十磅以上增減?						<input type="checkbox"/>	<input type="checkbox"/>
23. Are you currently taking any medication? 你目前是否接受治療或服用藥物?						<input type="checkbox"/>	<input type="checkbox"/>
24. Have you smoked cigarettes with the past 12 months? If yes, 在過去一年曾否吸煙? 如有, a. Average no. of sticks daily? 每日平均吸煙的支數? _____ b. For how many years have you smoked? 已吸煙多少年? _____						<input type="checkbox"/>	<input type="checkbox"/>
25. Do you frequently have alcoholic drinks? If so, please state your average consumption and type. 閣下是否經常性地飲酒? 若答是, 請說明平均數量及種類。						<input type="checkbox"/>	<input type="checkbox"/>
26. In the case of female lives. 適用於女性							
a. Are there any symptoms of gynaecological disease or have you ever had complications of pregnancy during gestation in the past 10 years (eg. ectopic pregnancy, miscarriage, disseminated intravascular coagulation, diabetes, hypertension, etc.)? 有否婦科疾病的症狀或在過去十年, 閣下曾否在妊娠期間患有併發症(例如: 宮外孕、流產、瀰漫性血管內凝血、糖尿病或血壓高等)?						<input type="checkbox"/>	<input type="checkbox"/>
b. Are the menses normal? 月經是否正正常?						<input type="checkbox"/>	<input type="checkbox"/>
c. If at present pregnant, when is confinement due? 若閣下現在懷孕, 請說明分娩日期?						<input type="checkbox"/>	<input type="checkbox"/>
I have read the above statements and answers. They are complete and true to the best of my knowledge and belief and form an integral part of the application of HSBC Life (International) Limited and the policy to be issued. 本人已細閱以上聲明與答覆, 確信其為真實無訛, 並明瞭以上一切資料將構成滙豐人壽保險(國際)有限公司人壽保險申請書之部分內容並為將發出保單之基礎。							
I authorise any physician, hospital, clinic, insurance company or other individual organisation or government office that has any records or knowledge of the Proposed Insured to disclose to HSBC Life (International) Limited or its representative any information relevant to this application. 本人授權任何知道本人健康情況及據有任何紀錄之醫生、診所、保險公司或其他機構或人士向滙豐人壽保險(國際)有限公司或其代表提供受保人之有關資料。							
Signature 簽署: _____				Date 日期: _____			
For Office Use Only		Marketing Executive		Serial Number		Policy Number	

(文義如有歧異, 以英文為準。)