Additional Medical Questionnaire

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.

General Information			
Name:		Blood pressure:	
Date of Birth:		Pulse:	
Height:	BMI:	Tobacco use:	
Weight:		Alcohol use:	

Personal Medical History		
Medical	Medication	Start Date
Surgical	Pathology	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 and Stamp: .....