



4 Has the patient previously had the same or similar condition?

Yes  No

If "Yes", please state the first treatment date

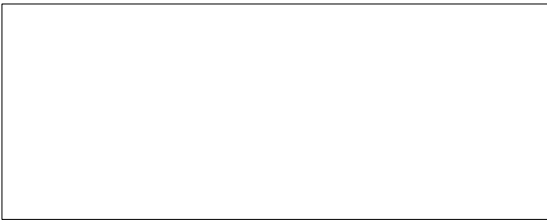
/  /  (dd/mm/yyyy)

Please state symptoms or condition presented:

\_\_\_\_\_

**DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST**

I, the undersigned, certify that I have examined the above Person Covered and all statement made and answers given are true and to the best of my knowledge and belief.



Signature and Official Stamp

Name: \_\_\_\_\_

Address:

Date:  /  /  (dd/mm/yyyy)