Questionnaire

Respiratory Diseases

Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Other ❑

SURNAME: .... **FIRST NAME(S)**: ....
Address : ....
Date and Place of birth : ………………………………………. Profession : ....

		YES	NO	Please specify :
1	**Disease**			
	Date of onset of the disease:			Date: ……./…………./…………
	Have you undergone medical investigations?	☐	☐	
	A chest X-ray	☐	☐	Date: ……./…………./………… Result:
	A respiratory/Lung function test	☐	☐	Date: ……./…………./………… Result
	Or other medical investigations	☐	☐	If yes, please specify : Date: ……./…………./………… Result
	What is/was the exact diagnosis:			……………………………………………………….
2	**Treatment**			
	Have you undergone any treatment? e.g. tablets, injections and inhalers:	☐	☐	Please specify names of medication, dosage and how often taken
	Currently	☐	☐	
	In the past	☐	☐	
	Have you ever taken oral steroids? e.g. Prednisolone, Pulmicort, etc	☐	☐	Please specify date(s) and duration of treatment
	Do you use a peak flow meter or spirometer and record the results?	☐	☐	If yes, please specify your lowest and highest readings in the last 3 months …………………………………………………………
	How often do you attend for follow-up?			…………………………………………………………
	When was your last consultation?			…………………………………………………………
	Have you been admitted to hospital?	☐	☐	Please specify reason(s), date(s), duration(s)
	Is hospital admission envisaged in the near future?	☐	☐	

3	**Symptoms**	YES	NO	
	Please describe your symptoms			
	Can you indicate frequency of symptoms/attacks?	☐	☐	Per month :
		☐	☐	Per year :
	When was the last occurrence of symptoms/attack:			Date: ……./…………./…………
	Are you breathless?	☐	☐	
	On intense effort	☐	☐	
	On mild effort	☐	☐	
	Permanently	☐	☐	
	Are you aware of any specific provoking cause which trigger your symptoms?	☐	☐	
	Exercise	☐	☐	
	Stress	☐	☐	
	Allergy	☐	☐	
	Do you Smoke?	☐	☐	Please specify the daily tobacco consumption:
	Have you been off work with this condition?	☐	☐	Please specify date(s) and duration
	Have you any limitations of physical activity	☐	☐	

It is imperative that this questionnaire be completed by the insurance applicant; all the questions must be completed. Applicants should be advised to consult their doctor or any other medical practitioner if they are not confident they will remember to disclose all health details that may be relevant.

I authorise your company to forward this information to its Reinsurers and approved professional organisations. I agree this form will constitute part of my application for Income Protection and that failure to disclose any material fact known to me may invalidate the contract.

I declare that to the best of my knowledge the answers I have given (whether in my handwriting or not) are true and complete. I confirm I have read and understand the disclosure notes in this form.

Name .... Date................................. 20……..
Signature of the insurance applicant

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