

Respiratory Disorder Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/____

1. Medical diagnosis : asthma bronchitis emphysema pneumonia other : _____

2. Please indicate which of the following apply to your condition, and provide us with further details :

Symptoms

- Chronic cough
- Sputum (yellowish-greenish color)
- Sputum (with presence of blood)
- Wheezing
- Shortness of breath
- Other _____

Details (dates and results)

Treatment / Surgery

- Antibiotic
- Inhaler(s) / puffer(s)
- Maximist
- Oral medication
- Surgery (specify): _____
- Oxygen
- Other: _____

Details (dates and results)

3. Are you currently taking any medication? If yes, please provide details. Yes No

Name of Medication	Dosage	Quantity per Day	Quantity per Month (if taken as needed)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Date you first experienced symptoms or attacks : _____

5. Frequency of symptoms or attacks : _____

6. Date of your last symptoms or attack(s) : _____

7. Was any hospitalization required for any of these conditions? Yes No
 If yes, dates and duration: _____

8. Was any time off work required for any of these conditions? Yes No
 If yes, dates and duration: _____

9. Do you have any pending consultation, treatment or surgery? Yes No
 If yes, please provide details (date, treatment, name of attending physician). _____

10. Name and address of your attending physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

Signature of proposed insured (parent or legal guardian if a minor)

Date (DD/MM/YYYY)