Respiratory disorders questionnaire - Applicant

(Includes asthma, bronchitis, emphysema, chronic obstructive airways disease, etc.)

Full name:

Application number:

1. Please indicate the precise diagnosis of your respiratory problem, if known.

- Asthma ☐
- Chronic bronchitis ☐
- Chronic obstructive airways disease ☐
- Emphysema ☐
- Pulmonary tuberculosis ☐
- Bronchiectasis ☐
- Obstructive sleep apnoea ☐
- Others (please specify) ☐

2. Regarding your symptoms:

a) When did you first have symptoms?

b) Please describe your symptoms and how they affect you.

c) How many attacks have you had in the last 12 months?

d) When did you last have symptoms?

e) Are you aware of any specific factor(s) which trigger your symptoms, such as exercise, stress, or allergy? Yes ☐ No ☐

If YES, please provide details.

f) Do your symptoms restrict your activities in any way? Yes ☐ No ☐

If YES, please provide details.

3. Regarding your medical care:

a) Please advise name and address of the medical professional who you attend regarding your condition.

b) How often do you attend and when was your last appointment?

c) Have you had any x-rays, pulmonary function tests or other investigations for this condition? Yes ☐ No ☐
If YES, please provide details including dates of investigations and results.

d) Please provide details of all treatments taken within the last 12 months, including any tablets, inhalers or any other form of treatment received. Please advise drug names, dosage and how often taken.

e) Have you ever taken oral steroids, e.g. Prednisolone? Yes ☐ No ☐
If YES, please provide full details including date(s), dose and duration of treatment.

f) Have you ever been admitted to hospital for your condition? Yes ☐ No ☐
If YES, please provide full details including dates, duration and treatment.

4. Do you use a peak flow meter and record the results? Yes ☐ No ☐
If YES, please mention the frequency and also your lowest and highest readings in the last 3 months.

5. Have you smoked cigarettes or any other form of tobacco in the last 2 years? Yes ☐ No ☐
If YES, how much do you smoke and if now stopped advise since when?

6. Have you lost more than one week off work with this condition in the last 2 years? Yes ☐ No ☐
If YES, please provide details including dates and duration of time off work.

7. Are there any aspects of your job which exacerbate, or are made more difficult, by your condition? Yes ☐ No ☐
If YES, please provide details including which aspects of your job are most problematic.

8. Please provide any additional information on your condition which you feel will be helpful in processing your application.

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.
I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature

Date