

**HEADACHE AND MIGRAINE**

**QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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| **First Name:** |       | **Last Name:** |       |
| **Date of Birth** (mm/dd/yyyy): |       | **Policy/Application No.:** |       |

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| --- |
| 1. Did or do your headaches occur in association with a neurological disorder (e.g., brain tumor, etc.), vascular disease (e.g., hypertension) or a head injury?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. Did or do your headaches occur in association with a minor disease (e.g., flu)?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. Did or do your headaches occur in association with a psychosomatic or mental or nervous disorder?
 |
| [ ]  Yes (Please provide details.) [ ]  No |
|       |
| 1. What type of headache do you experience?
 |
| [ ]  Cluster Headache | [ ]  Migraine | [ ]  Others, please specify:       |
| [ ]  Horton’s Headache | [ ]  Tension Headache |
| 1. How often do you have symptoms?       day(s) per month
 |
| 1. Please describe the nature of pain or discomfort.
 |
| [ ]  Stabbing | [ ]  Squeezing | [ ]  Chest Heaviness |
| [ ]  Burning | [ ]  Constricting | [ ]  Others:       |
| 1. Do you take medication?
 |
| [ ]  No | [ ]  As needed | [ ]  Continuous (1 type only) | [ ]  Continuous (more than 1 type) |
| Name of Medication | Date Prescribed (Month/Year) | Frequency and Dosage | Date Medication Stopped (Month/Year) | Reason |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| 1. Please provide any additional information that you feel is important.
 |
|       |
| 1. Please provide details regarding the doctors and/or specialists you see in relation to this condition:
 |
| Name of Doctor, Hospital or Clinic | Address | Date of Last Consultation (Month/Year) |
|       |       |       |
|       |       |       |

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| **DECLARATION** |
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| **I confirm that the answers I have given are, to the best of my knowledge, true and correct 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 my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.**  |

|  |  |
| --- | --- |
| **Name:** |       |

|  |  |
| --- | --- |
| **Signature:** |  |

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| --- | --- |
| **Date of Signing:** |       |

