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**HEADACHE AND MIGRAINE**

**QUESTIONNAIRE – APPLICANT**

(This questionnaire will form part of the application)

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

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

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

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