RESPIRATORY QUESTIONNAIRE – APPLICANT

(This questionnaire will form part of the application)

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

1. Please state the precise diagnosis or nature of the condition. Attach a copy of any medical report if available.		
☐ Asthma	☐ Chronic Bronchitis	☐ Pulmonary Emphysema/COPD
☐ Others: _____		

2. What triggers the asthma/respiratory disorder?		
☐ Dust/pollution	☐ Food	☐ Exercise
☐ Change in climate	☐ Respiratory infection	☐ Others (please specify): _____

3. How often do you have attacks?			
☐ Weekly	☐ Monthly	☐ Yearly	☐ Others: _____

4. When was your last attack?	
5. Was medical consultation sought?	☐ Yes (Please provide details.) ☐ No

6. What is your current treatment/medication or which treatment/medication was given?

☐ Yes (Please provide details.) ☐ No

Name of Medication	Date Prescribed (Month/Year)	Frequency and Dosage	Date Medication Stopped (Month/Year)	Reason

7. Have you been admitted to a hospital/facility due to this condition?

☐ Yes (Please provide details.) ☐ No

Date Admitted (Month/Year)	Date Discharged (Month/Year)	Name of Hospital/Facility	Reason for Confinement

8. Have you ever had a history of "Status Asthmaticus" or extreme asthma emergency?

☐ Yes (Please provide details.) ☐ No

9. Did you ever have cardiac arrest due to asthma respiratory disorder?	☐ Yes ☐ No

10. Do you smoke?	☐ Yes (Please provide details.) ☐ No

Type	Details (Number of sticks/packs/ml per day)
☐ Cigarettes	

☐ E-cigarettes	
☐ Vape	
☐ Smokeless Tobacco	

11. Have you taken time-off work due to the asthma/respiratory disorder?

☐ Yes (Please provide details.) ☐ No

12. Please provide any additional information that you feel is important.

13. 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)

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:	
Signature:	
Date of Signing:	