Sagicor

ASTHMA/BRONCHITIS/RESPIRATORY QUESTIONNAIRE

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

Name of Proposed Insured:	Policy No:
Occupation:	Date of Birth: (DD/MM/YY)

1. Please state the precise diagnosis, or nature of the condition you are suffering from e.g asthma, bronchitis, etc.

   _____

2. (a) When did you first have an attack? _____

   (b) Please describe your symptoms. _____

3. (a) How many attacks have occurred in the past 12 months? _____

   (b) How often do you typically experience symptoms? _____

   (c) How long do symptoms usually last? _____

   (d) How many attacks occurred 1-2 years ago? _____

   (e) Do your symptoms wake you up at night? ☐ Yes ☐ No
   If yes, how often per month? _____

4. Are your symptoms precipitated by seasonal changes, exercise, respiratory infections, stress, allergy etc? ☐ Yes ☐ No
   If yes, please type, daily dosage and dates:

   _____

5. What was the date of the last attack/ symptoms? _____

6. Are the attacks: Mild? ☐ Moderate? ☐ Severe? ☐

   (a) Are you productive of Sputum?..... ☐ Yes ☐ No
   (b) Have you lost time from work?..... ☐ Yes ☐ No
   (c) Have you ever coughed up blood?..... ☐ Yes ☐ No

   If "Yes", when_____

7. Have you ever been Hospitalised or had out-patient follow up for this condition? ☐ Yes ☐ No
   If "Yes", when, where and length of time?

   _____

   _____

   _____

8. (a) Are you under treatment or taking medication? ..... ☐ Yes ☐ No
   If yes, give type, daily dosage and dates.

   _____

   _____

(b) Have you ever used steroids or oxygen therapy?..... ☐ Yes ☐ No

If "Yes", give type, daily dosage and dates: _____

(c) Have you ever taken steroids by mouth?..... ☐ Yes ☐ No

If "Yes", when did you last take pills?_____

9. (a) Please give names and addresses of all doctors consulted and dates for any of the above:

Name(s)	Address(es)	Dates

(b) Please give date and results of any Chest X-Rays or Pulmonary Function tests done:_____

_____

(c) Do you use a Peak Expiratory Flow Rate Meter? ..... ☐ Yes ☐ No

If so, please state results of last test: _____

_____

10. Are you short of breath or do you wheeze on exertion? ..... ☐ Yes ☐ No

If "Yes", explain _____

_____

11. Do you smoke?..... ☐ Yes ☐ No

If, "Yes", state daily consumption _____

I hereby agree that this supplement shall form a part of the application and of the policy issued thereunder, if any, and that it shall be binding on any person or persons who shall have or claim any interest under such policy. I have carefully read the above questions, statements, and answers and all such statements and answers are correctly recorded and are true as written above. I agree that failure to disclose any material fact known to me shall invalidate my insurance.

Dated this _____day of _____, 20_____

_____ Advisor/Witness

_____ Signature of Proposed Insured

_____ Applicant *(if other than Proposed Insured)*