GASTROINTESTINAL QUESTIONNAIRE

Reset Form

Name	Date of Birth (dd/mmm/yy)	Application #

1. When did the first symptom occur or when was the condition first detected?

Has any specific cause been identified for your condition?

How often do symptoms occur and how long do they last?

When did you last have symptoms?

Date & results of last x-ray, ultrasound, Barium swallow/enema, scope: ❍ never had one

Do you have any tests pending? If so, please state test & scheduled date:

2. Do you or have you suffered from: ❍ rectal bleeding ❍ vomiting blood ❍ difficulty swallowing
If yes, please give details.

Are you currently experiencing any symptoms? ❍ Yes ❍ No If no, how long have you been symptom free? _____
If yes, describe current symptoms:

Name address & phone number of medical advisor(s) consulted:

Name	Address (number and street)	City	Province	Telephone

Date of last medical advisor(s) consult (dd/mmm/yy):

Details of any medication taken (type, dose, frequency):

❍ Still taking medication | Date medication was stopped (dd/mmm/yy):

3. Do you require other types of treatment such as dietary modifications? ❍ Yes ❍ No If yes, please give details below.

Do you currently or have you ever required intravenous or tube feeding? ❍ Yes ❍ No If yes, please give details below.

Have you ever been hospitalized for this condition? ❍ Yes ❍ No If yes, please give details below.

Have you ever required emergency treatment for this condition? ❍ Yes ❍ No If yes, please give details below.

Is there any physical restriction or impairment because of your condition? ❍ Yes ❍ No If yes, please give details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition? ❍ Yes ❍ No
If yes, please give details below.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

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