

RESPIRATORY QUESTIONNAIRE

Name	Date of Birth (dd/mmm/yy)	Application #
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1. Do you or have you suffered from:

Chronic bronchitis Asthma Emphysema Pneumonia Chronic obstructive pulmonary disease (COPD)
 Chronic cough Allergies Other (explain)

Do you experience any:

Shortness of breath Wheezing Coughing Laboured breathing Lips turning blue Other (explain)

2. When did the first symptom occur?

Are there any known triggers for your symptoms?

Allergies Seasonal (cold/heat) Respiratory infections Exercise Other (explain)

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

When did you last have symptoms?

Are the symptoms

Mild Moderate Severe Productive of sputum Productive of blood

Compared to previous years is the frequency, severity and pattern of symptoms Same Less Increased

Date & results of last pulmonary function test, chest x-ray or allergy test: (dd/mmm/yy):

never had one

3. Please provide details for use of:	x per day	x per week	x per month	Date last used (dd/mmm/yy)
Rescue Inhaler (Ventolin, Salbutamol)				
Maintenance Inhaler (Flovent, Advair)				
Nebulizer Pump				
Steroids (Cortisone, Prednisone)				
Other				

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

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.

Have you ever used any form of tobacco? Yes No If yes, please give details below. Date stopped using (dd/mmm/yy)

Are you presently using any form of tobacco? Yes No If yes, please indicate usage.

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