

<input style="width: 95%; height: 20px;" type="text"/> Last name	<input style="width: 95%; height: 20px;" type="text"/> First name
Date of birth: <input style="width: 15%; height: 20px;" type="text"/> / <input style="width: 15%; height: 20px;" type="text"/> / <input style="width: 15%; height: 20px;" type="text"/> <small>Year Month Day</small>	<input style="width: 95%; height: 20px;" type="text"/> Application or Contract No.

1 Nature of your respiratory disorder:

Asthma Emphysema Sleep apnea
 Chronic bronchitis Obstructive pulmonary disease Other: _____

2 Date of diagnosis: /
Year Month

3 a) Specify whether the symptoms are Constant Episodic

b) Usual length of the symptoms: _____

c) Date of the first episode, including one or more attacks: /
Year Month

d) Date of the last symptoms: /
Year Month

e) Length of the last episode: _____

4 Name and mailing address of all physicians or other healthcare professionals consulted for this condition.

Name	Address	Date of consultation
_____	_____	<input style="width: 15%; height: 20px;" type="text"/> / <input style="width: 15%; height: 20px;" type="text"/> <small>Year Month</small>
_____	_____	<input style="width: 15%; height: 20px;" type="text"/> / <input style="width: 15%; height: 20px;" type="text"/> <small>Year Month</small>
_____	_____	<input style="width: 15%; height: 20px;" type="text"/> / <input style="width: 15%; height: 20px;" type="text"/> <small>Year Month</small>

5 Are you taking any medication for this condition? Yes No

If so, specify _____

How frequently do you take the drugs prescribed?

Every day When suffering a cold or flu Only during episodes or attacks

If not, have you ever done so? Yes No

If so, specify the medications, the reason and the cessation date. _____

6 Are you receiving or have you received treatment (CPAP, respiratory therapy or other)? Yes No

If so, specify the frequency of use. Every day When suffering a cold or flu Only during episodes or attacks

Are you still receiving this treatment as directed by your physician? Yes No

7 Have you undergone or do you have to undergo any tests or examinations in connection with this condition? Yes No **If so, specify.**

Test/examination	Result (if applicable)	Date												
<input type="checkbox"/> Chest X-ray	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
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<input type="checkbox"/> Pulmonary function test	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
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<input type="checkbox"/> Scan	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
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<input type="checkbox"/> Sleep study	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
Year					Month									
<input type="checkbox"/> Other: _____	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
Year					Month									

8 Have you been hospitalized as a result of this condition? Yes No **If so, specify.**

Name of hospital	Address	Date of admission												
_____	_____	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month
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Year					Month									

9 Have you ever had to go on disability leave because of this condition? Yes No

If so, specify: Less than one week per year More than one week per year



If more than one week, specify the start date and length of each period.

Start date	Length (number of weeks)												
<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td>Year</td><td> </td><td> </td><td> </td><td> </td><td>Month</td></tr> </table>							Year					Month	_____
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Year					Month								

10 Please provide all relevant additional information. _____

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at _____ on this _____ day of _____ 20____.

 Signature of proposed insured or of legal guardian, if the proposed insured is under age 18 in Quebec or under 16 in other provinces.	 Signature of witness
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