La Capitale

RESPIRATORY DISORDERS QUESTIONNAIRE

Last name

First name

Date of birth: Year Month Day

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
		Year Month
		Year Month
		Year Month

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

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

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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
☐ Chest X-ray		Year Month
☐ Pulmonary function test		Year Month
☐ Scan		Year Month
☐ Sleep study		Year Month
☐ Other:		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
		Year Month
		Year Month
		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)
Year Month	
Year Month	

10 Did you make a full recovery? ◯ Yes ◯ No **If so,** specify the date of the last symptoms. Year Month

11 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 _____ .

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

X _____
Signature of witness

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