INTESTINAL DISORDERS QUESTIONNAIRE

Last name ____________________ First name ____________________

Date of birth: Year | Month | Day

Application or Contract No. ____________________

1 What is the nature of your intestinal disorder?

☐ Celiac disease (gluten intolerance) ☐ Ulcerative colitis
☐ Crohn's disease ☐ Ulcerative proctitis
☐ Irritable bowel syndrome ☐ 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 episode, including one or more attacks: Year | Month

4 Name and address of your attending physician: ____________________

5 Have you ever consulted or should you consult a specialist (gastroenterologist, surgeon, etc.)? ☐ Yes ☐ No

If so, specify the dates of consultations that have taken place or are scheduled, as well as the name and mailing address of any physicians consulted.

Name	Address	Date of consultation
		Year / Month
		Year / Month
		Year / Month

6 Are you taking medication for this condition? ☐ Yes ☐ No

If so, specify. ____________________

If not, have you ever done so? ☐ Yes ☐ No **If so**, specify the medications, the reason and the cessation date. ____________________

7 Have you been prescribed a diet? ☐ Yes ☐ No **If so**, please specify. ____________________

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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8 Do you have any extra-intestinal complications such as anemia, arthritis, fistula, hemorrhage, perforation, stenosis, skin problems, liver disease, eye disease, thrombophlebitis, etc.? ☐ Yes ☐ No **If so**, specify. ____________________

9 Have you undergone or do you have to undergo tests or examinations (gastroscopy, colonoscopy, scan, etc.)? ☐ Yes ☐ No **If so**, specify.

Type of test or examination	Name of hospital	Address	Date	Result
			Year Month	
			Year Month	
			Year Month	

10 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

11 Have you had or will you have to have surgery? ☐ Yes ☐ No **If so**, specify.

Surgical procedure	Name of hospital	Date
		Year Month
		Year Month

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

If so, specify the start date and length of each disability period.

Start date	Length (number of weeks)
Year Month	
Year Month	

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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