RESPIRATORY QUESTIONNAIRE

PACIFIC CROSS

(To be completed by the applicant)

Name, First name: _____

Dated (day/month/year): _____

This questionnaire will form part of the application.

If any questions below are answered "Yes", please supply full details below including dates and names of doctors and institutions where applicable.

1. With regard to your chest complaint:
   a. What is the nature of these episodes? Please describe a typical episode.

      _____

   b. At what age did you have the first episode? _____ years
   c. What was the date of the most recent episode? _____

2. How frequently do these episodes occur? State number per year: _____
3. Do you receive treatment for these episodes? _____

   ❑ No
   ❑ Yes – please provide details:
   a) Nature of treatment (bronchodilators, aerosol inhalants, steroid therapy)

   _____

   b) In which category mentioned below does such treatment fall?

   ❑ Only occasional treatment during episodes
   ❑ Treatment over a period of months
   ❑ Continuous treatment
   ❑ Short courses of steroids

4. Were you ever hospitalized for asthma?

   ❑ No
   ❑ Yes – please provide details: _____

5. Do you know what causes these episodes (allergies, stress, exercise)?

   ❑ No
   ❑ Yes – please provide details: _____

6. Is your chest congested between episodes?

   ❑ No
   ❑ Yes – please provide details: _____

7. Have you ever experienced any limitation of ability to work or been absent from work as a result of an episode?

   ❑ No
   ❑ Yes – please state number of days: _____

8. Have you ever had your chest X-rayed or undergone any pulmonary function tests?

   ❑ No
   ❑ Yes – please provide details: _____

9. Please state any further relevant particulars including name and address of personal medical attendant or attendants

   _____

   _____

10. Do you smoke?
    - ❑ No
    - ❑ Yes – how much: _____

11. Have you ever or do you now work in a dusty environment or with asbestos or do you have any hobbies which may affect your asthma, e.g. woodwork, pigeon breeding?
    - ❑ No
    - ❑ Yes – please provide details: _____

I declare that the answers I have given are, to the best of my knowledge, true and I have not withheld any material information that may influence the assessment of acceptance of this proposal. I agree that this form will constitute part of my proposal for health insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signed: _____ Date (day/month/year): _____