



Respiratory (Asthma) Questionnaire

(to be completed by Proposed Insured)

500-5000 Yonge Street
Toronto, ON M2N 7J8
Fax: 1-877-767-0477

Policy Number: _____

PLEASE PRINT

Name of Proposed Insured: _____ Date of Birth: DD / MM / YYYY

1 Have you ever suffered from bronchitis, asthma, chronic obstructive pulmonary disease? Yes No

Date of first attack: DD / MM / YYYY Date of last attack: DD / MM / YYYY

Frequency of attacks: _____ Average duration: _____

2 Are the attacks: mild? moderate? severe?

Have you ever coughed up blood? Yes No

Are you short of breath? Yes No

Do you wheeze on exertion? Yes No

3 What medication or treatment have you required (Inhalers, Cortisone, Prednisone or other steroids)?

4 Have you had lung or pulmonary function tests? Yes No

If results are known are they Normal or Abnormal? _____

Have you had chest x-rays? Yes No

If results are known are they Normal or Abnormal? _____

5 a) Have you lost time from work? Yes No

Date ceased work: DD / MM / YYYY Date resumed work: DD / MM / YYYY

b) Were you hospitalized? Yes No

From _____ to _____ Name of hospital: _____

6 Please give names and addresses of all your attending doctors, with dates in each instance:

7 a) Do you smoke? Yes No If "Yes," explain and state daily quantity: _____

b) Have you ever smoked? Yes No If "Yes," when did you last smoke? DD / MM / YYYY

8 Additional Comments: _____

I understand that my answers to the above questions will be relied on by *ivari* in establishing my premium rate. If the above answers are not true, complete and correctly recorded, any policy issued as a result of this questionnaire (being part of the Application for Insurance) may be rendered void on the grounds of misrepresentation or fraud.

I hereby declare that I have read all the questions and answers in this questionnaire and the statements and answers given above are true, complete and correctly recorded to the best of my knowledge and belief. I understand and agree that this questionnaire shall form part of my Insurance Application to *ivari*.

Dated at _____ this _____ day of _____, 20 _____.

Signature of Proposed Insured

Signature of Witness

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