Insurance

RESPIRATORY DISORDER QUESTIONNAIRE

Name of Proposed Insured: ______ **Application/Policy No:** ______

1. Have you ever had any indication of or sought advice or been treated for any disease or disorder of the lungs or respiratory system? . . . Yes ☐ No ☐

   If yes, please specify: ☐ Asthma ☐ Chronic cough ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Pneumonia ☐ Emphysema ☐ Chronic bronchitis ☐ Bronchiectasis ☐ Other (please specify): ______

2. Do you have episodes of symptoms such as wheezing, coughing, shortness of breath? . . . Yes ☐ No ☐

   If yes, please specify:
   a) Date of first episode: ______
   b) Date of last episode: ______
   c) Number of episodes, past 12 months: ______
   d) Number of episodes, past 24 months: ______
   e) Duration of episodes: ______
   f) Severity of episodes: ☐ Mild ☐ Moderate ☐ Severe

3. a) Are you currently taking any medication or receiving any treatment for this condition? . . . Yes ☐ No ☐
   If yes, provide date and details of treatment, name(s), dosage(s) and frequency of use of medication(s):

   b) Provide name(s) and dosage(s) of medication prescribed for acute or symptomatic episodes:

4. Have you ever consulted an emergency room or been hospitalized for this condition? . . . Yes ☐ No ☐
   If yes, advise date(s), reason(s) and name and address of hospital(s):

5. Have you been referred to a specialist for this condition? . . . Yes ☐ No ☐
   If yes, provide full name(s) and addresses of specialist(s) consulted, frequency of follow-up visits and date of last consultation:

6. a) Have you undergone any diagnostic tests? . . . Yes ☐ No ☐
   If yes, specify type(s), date(s), and results:
   ☐ Chest x-ray ______ ☐ Bronchoscopy ______
   ☐ Pulmonary function test ______ ☐ CT scan ______
   ☐ Peak flow test ______ ☐ Other (specify) ______

   b) Have any tests or investigations been recommended? . . . Yes ☐ No ☐
   If yes, specify type(s) of test or investigation(s) and date(s) scheduled:

7. Between episodes, do you have any ongoing symptoms such as shortness of breath, wheezing or cough? . . . Yes ☐ No ☐

   If yes: a) Describe symptoms: ______
   b) Do symptoms occur: ☐ At rest ☐ On exertion ☐ Other (specify): ______
   c) Advise frequency and severity of symptoms: ______

   If no: How long have you been completely free of any symptoms? ______

(continued on following page)

Insurance

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8. a) Have you ever coughed up blood? . . . . . Yes ☐ No ☐

   If yes, provide details: ______

   b) Do you have chronic sputum production? . . . . . Yes ☐ No ☐

9. Have you ever used cigarettes, cigarillos, e-cigarettes, more than an average of 1 large cigar per month, small cigars, chewing tobacco, pipes or bowls, snuff, smoking cessation products, tobacco substitutes, nicotine products, marijuana, hashish, betel nuts, betel leaves, hookah, supari, shisha, paan or gutka? . . . . . Yes ☐ No ☐

   If yes, provide details:

Type Used	Quantity Used	Frequency Of Use	Date Last Used

10. a) Do you have any of the following conditions? ☐ Hay fever ☐ Nasal polyps ☐ Sinusitis

    b) Do you have exercise or cold induced asthma? . . . . . Yes ☐ No ☐

    c) Have you had pneumonia or bronchitis? . . . . . Yes ☐ No ☐

    If yes, specify number of episodes and date of last occurrence of each:

11. Is there a known allergic basis to your symptoms? . . . . . Yes ☐ No ☐

    If yes, indicate allergens: ______

12. Have you ever lost any time from work due to this condition? . . . . . Yes ☐ No ☐

    If yes, provide details including dates and duration of time off work:

13, Have your job duties or daily activities ever been restricted or modified in any way because of this condition? . . . . . Yes ☐ No ☐

    If yes, describe restrictions, modifications or limitations:

14. Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations:

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: ______

Date (DD/MM/YYYY): ______

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