RBC Insurance

CHEST PAIN QUESTIONNAIRE

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

1. Please provide a description of the chest pain or discomfort:
   - ☐ Aching ☐ Throbbing ☐ Heavy ☐ Short duration ☐ Prolonged (> 5 minutes)
   - ☐ Sharp ☐ Stabbing ☐ Dull ☐ Constricting ☐ Vice like
   - ☐ Shortness of breath ☐ Other (specify): ☐ Sudden ☐ Gradual

2. Where was pain located?
   - ☐ Over the left chest ☐ Over the right chest ☐ Mid chest
   - ☐ Under the sternum ☐ In the back ☐ Variable

3. Did the pain radiate to other parts of your body? ☐ Yes ☐ No **If yes**, please provide details:
   - ☐ To the left arm ☐ To the right arm ☐ To both arms ☐ Across the shoulder blades
   - ☐ To the jaw ☐ Down to the fingertips ☐ Other (specify):

4. Did or do the symptoms occur during or after:
   - ☐ Exertion ☐ Strain ☐ Exposure to cold ☐ Exercise
   - ☐ Rest ☐ Meals ☐ Excitement ☐ Fatigue

5. Are your symptoms relieved by (specify):
   - ☐ Lying down ☐ Stopping exertion ☐ Anti-angina medication
   - ☐ Antacid medication ☐ Other (specify):

6. Date of first episode of chest pain: _____ Date of last episode of chest pain: _____
   Frequency of episodes of chest pain: _____ Duration of episodes of chest pain: _____

7. a) Have any tests or investigations been completed? . . . . . Yes ☐ No ☐
   If yes, specify type, date, and results:
   - ☐ ECG (electrocardiogram) _____
   - ☐ Echocardiogram _____
   - ☐ Stress/Exercise ECG _____
   - ☐ Perfusion test (MIBI) _____
   - ☐ Cardiac catheterization _____
   - ☐ Chest x-ray _____
   - ☐ Other (please specify) _____

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

8. Has your physician given you a diagnosis? . . . . . Yes ☐ No ☐
   If yes, provide full details, including the date of diagnosis:

9. a) Have you ever been advised to take any medication on a regular or an 'as needed' basis? . . . . . Yes ☐ No ☐
   If yes, indicate name(s), dosage(s) and frequency of medication(s):

   b) Are you currently taking any medication: . . . . . Yes ☐ No ☐
   If yes, indicate name(s), dosage(s) and frequency of medication(s):

   c) Have you had or been advised to have any other treatment or surgery for this condition? . . . . . Yes ☐ No ☐
   If yes, provide details, including date(s) and results:

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10. 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):

11. Are you followed by your family physician on a regular basis for this condition? . . . . . Yes ☐ No ☐
If yes, specify the frequency of follow-up visits and date of the last consultation:

12. 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-ups visits and date of the last consultation:

13. 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:

14. 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:

15. 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):