

Last name		First name		Date of birth			File number
				D	M	Y	
Agent (Name)		Code	S.U.	Agency (Name)		Agency (Code)	

QUESTIONNAIRES

Completing the appropriate questionnaire(s) will allow us to make a decision more rapidly.

- | | | |
|---|---|--|
| 1 HIGH BLOOD PRESSURE | 2 DIGESTIVE TROUBLE | 3 DIZZINESS, LOSS OF CONSCIOUSNESS, CONVULSIONS, EPILEPSY |
| 4 URINARY TROUBLE | 5 DEPRESSION OR NERVOUS DISORDER | 6 RESPIRATORY TROUBLE |
| 7 MUSCULOSKELETAL TROUBLE (INCLUDING NECK AND BACK PAIN) | 8 CHEST PAIN | 9 ARTHRITIS, RHEUMATISM, GOUT |

1 HIGH BLOOD PRESSURE

Have you ever been told that you have high blood pressure? Yes No

If yes, answer the following questions:

- a) When? _____ (date) What were the figures? Systolic: _____ Diastolic: _____
- b) Have you ever received treatment for high blood pressure? Yes No If yes, nature of treatment: _____
- c) What medication were you prescribed? _____ Dosage: _____ Duration: _____
- d) Do you still take it? Yes No When did you stop taking it? _____ Why? _____
- e) What is your current blood pressure? _____ Unknown
- f) Name of the physician who treated you or who is currently treating you:
 Last name: _____ First name: _____ Date of last consultation: _____
 Name of the clinic or hospital consulted most often: _____
 Address of the clinic or hospital:
 Address: _____ City: _____
 Province: _____ Postal code: _____ Phone: _____

2 DIGESTIVE TROUBLE

Do you or have you ever suffered from digestive or gastrointestinal trouble? Yes No

If yes, answer the following questions:

- a) Indicate the symptoms:
 CONSTIPATION DIARRHEA BLACK STOOL VOMITING BLOOD
 BLOOD OR MUCUS IN STOOL WEIGHT LOSS TROUBLES RELATED TO MEALS OTHER: _____
 Date of first episode: _____ Date of last episode: _____ Frequency: _____
- b) Diagnosis:
 DYSPEPSIA DUODENAL ULCER GASTRIC ULCER
 COLITIS ULCERATIVE COLITIS CROHN'S DISEASE
 OTHER: _____
- c) Examinations:
 BARIUM ENEMA BARIUM MEAL EXAMINATION OF COLON (COLONOSCOPY)
 OTHER: _____ Date: _____ Results: _____
- d) Hospitalization? Yes No Surgery? Yes No
 If yes, details: _____ Date: _____ Results: _____
- e) Medication prescribed (name): _____ Dosage: _____ Duration: _____
 Current medication? Yes. Indicate which one: _____
 No. Since when: _____
- f) Complete recovery? Yes No If yes, indicate since when: _____
- g) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____
- h) Name of the physician who treated you or who is currently treating you:
 Last name: _____ First name: _____ Date of last consultation: _____
 Name of the clinic or hospital consulted most often: _____
 Address of the clinic or hospital:
 Address: _____ City: _____
 Province: _____ Postal code: _____ Phone: _____

3 DIZZINESS, LOSS OF CONSCIOUSNESS, CONVULSIONS, EPILEPSY

Do you or have you ever suffered from dizziness, loss of consciousness, convulsions, epilepsy? Yes No

If yes, answer the following questions:

- a) Have you ever had: DIZZINESS LOSS OF CONSCIOUSNESS CONVULSIONS
Date of first episode: _____ Date of last episode: _____ Frequency: _____
- b) Are you prone to fainting? Yes No If yes, date of last episode: _____ Frequency: _____
Reason: _____
- c) Indicate the symptoms: ANY SENSATION PRIOR TO EPISODE? Yes No TONGUE BITING LOSS OF URINE
 CONVULSIONS COMPLETE LOSS OF CONSCIOUSNESS
- d) Do you or have you ever suffered from epilepsy? Yes No If yes, kind of seizure: GRAND MAL PETIT MAL ABSENCE SEIZURES
Date of first attack: _____ Date of last attack: _____ Frequency: _____
- e) Examinations: ELECTROENCEPHALOGRAM CT SCAN OF BRAIN OTHER: _____
Date: _____ Results: _____
- f) Hospitalization? Yes No If yes, indicate the date: _____
- g) Medication prescribed (name): _____ Dosage: _____ Duration: _____
Do you take it regularly? Yes No If no, why did you stop? _____ Since when? _____
- h) Complete recovery? Yes No If yes, indicate since when: _____
- i) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____
- j) Name of the physician who treated you or who is currently treating you:
Last name: _____ First name: _____ Date of last consultation: _____
Name of the clinic or hospital consulted most often: _____
Address of the clinic or hospital:
Address: _____ City: _____
Province: _____ Postal code: _____ Phone: _____

4 URINARY TROUBLE

Do you or have you ever suffered from urinary trouble? Yes No

If yes, answer the following questions:

- a) Indicate the symptoms:
 PAIN WHEN URINATING DIFFICULTY IN URINATING URINARY TRACT INFECTION FREQUENT URINATION
 BLOOD IN URINE ANY STONE OR GRAVEL PASSED FEVER NAUSEA, VOMITING
Date of first episode: _____ Date of last episode: _____ Frequency: _____ Duration: _____
- c) Examinations: URINALYSIS CYSTOSCOPY PYELOGRAPHY CT SCAN OF ABDOMEN
 OTHER: _____
- d) Diagnosis: _____ Date: _____
- e) Hospitalization? Yes No Surgery? Yes No
If yes, details: _____ Date: _____
- f) Medication prescribed (name): _____ Dosage: _____ Duration: _____ Do you still take it? Yes No
- g) Complete recovery? Yes No If yes, indicate since when: _____
- h) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____
- i) Name of the physician who treated you or who is currently treating you:
Last name: _____ First name: _____ Date of last consultation: _____
Name of the clinic or hospital consulted most often: _____
Address of the clinic or hospital:
Address: _____ City: _____
Province: _____ Postal code: _____ Phone: _____

5 DEPRESSION OR NERVOUS DISORDER

Do you or have you ever suffered from depression or a nervous disorder including stress, overwork or burn out? Yes No

If yes, answer the following questions:

- a) Nature of disorder:
 DEPRESSION INSOMNIA NERVOUSNESS PALPITATION TREMOR
 SUICIDAL THOUGHTS ANXIETY FATIGUE, EXHAUSTION OTHER: _____
Date of first episode: _____ Date of last episode: _____ Number of episodes: _____
- b) Treatments: PSYCHOTHERAPY? Yes No If yes, by: Psychiatrist Psychologist General practitioner
Date: _____ Frequency: _____
- c) Hospitalization? Yes No If yes, indicate the date: _____
- d) Medication prescribed (name): _____ Dosage: _____ Duration: _____
- e) Do you still take it? Yes No If yes, indicate which: _____ If no, since when? _____
- f) Are you still under the care of a physician? Yes No If no, since when: _____
- g) Do you still have symptoms? Yes No If yes, indicate which: _____
- h) Complete recovery? Yes No If yes, indicate since when: _____
- i) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____
- j) Name of the physician who treated you or who is currently treating you:
Last name: _____ First name: _____ Date of last consultation: _____
Name of the clinic or hospital consulted most often: _____
Address of the clinic or hospital:
Address: _____ City: _____
Province: _____ Postal code: _____ Phone: _____

6 RESPIRATORY TROUBLE

Do you or have you ever suffered from respiratory trouble including bronchitis, asthma, emphysema or sleep apnea? Yes No

If yes, answer the following questions:

a) Nature of disorder:

ALLERGIES SLEEP APNEA ASTHMA BRONCHITIS CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
 EMPHYSEMA OTHER: _____ Date of diagnosis: _____

b) Indicate the symptoms:

SHORTNESS OF BREATH WHEEZING COUGH EXPECTORATION RALE SPITTING OF BLOOD
 OTHER: _____

What triggers the symptoms?

Allergies (pollen, dust, animal hair, etc.) Viral respiratory infection (influenza) Environmental irritants (smoke, toxic odours, etc.)
 Emotions Cold air Exercise Other: _____

Frequency of symptoms. Number of times: _____ /day, _____ /week, _____ /month

Date of the last crisis or episode: _____

Do the symptoms wake you up at night? Yes No If yes, number of nights: _____ /week

c) Have you consulted an emergency service in the last 12 months? Yes No If yes, indicate the dates: _____

d) Hospitalization? Yes No If yes, date: _____ Duration: _____ Hospital: _____

e) Examinations: POLYSOMNOGRAPHY CHEST X-RAY LUNG FUNCTION TEST (SPIROMETRY)
 OTHER: _____

f) Medication prescribed? Yes No

Name of current medication	Administration	Dosage
_____	<input type="checkbox"/> Inhaled <input type="checkbox"/> Oral/Buccal <input type="checkbox"/> Intravenous	_____ /day, _____ /week, _____ /month
_____	<input type="checkbox"/> Inhaled <input type="checkbox"/> Oral/Buccal <input type="checkbox"/> Intravenous	_____ /day, _____ /week, _____ /month
_____	<input type="checkbox"/> Inhaled <input type="checkbox"/> Oral/Buccal <input type="checkbox"/> Intravenous	_____ /day, _____ /week, _____ /month

g) Treatment prescribed: Yes No If yes, please give details below.

CPAP/BiPAP: Yes No Number of hours of use per night: _____ Pressure: _____

Others: _____

h) Complete recovery: Yes No If yes, indicate since when: _____

i) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____

j) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: _____

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

7 MUSCULOSKELETAL TROUBLE (INCLUDING NECK AND BACK PAIN)

Do you or have you ever suffered from musculoskeletal trouble including neck and back pain and sciatic nerve pain? Yes No

If yes, answer the following questions:

a) Probable cause: ACCIDENT SPORT POSTURE OTHER: _____

b) Site of the pain or discomfort:

BACK: Neck (cervical) KNEE OTHER JOINTS: _____
 Middle (thorax)
 Lower back (lumbosacral) including sciatic nerve

Date of first episode: _____ Date of last episode: _____ Number of times: _____

Duration of the longest episode: _____

c) Examinations: RADIOGRAPHY ARTHROSCOPY OTHER: _____

d) Diagnosis: _____ Date: _____

e) Hospitalization? Yes No Surgery? Yes No

If yes, details _____ Date: _____

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

g) Other treatment: TREATMENT BY CHIROPRACTOR PHYSIOTHERAPY MASSAGE THERAPY OTHER: _____

Date of first treatment: _____ Date of last treatment: _____ Number of consultations per year: _____

h) Since when are you free of discomfort? _____

i) Complete recovery: Yes No If yes, indicate since when: _____

j) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____

k) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: _____

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

8 CHEST PAIN

Do you or have you ever suffered from chest pain? Yes No

If yes, answer the following questions:

a) Indicate the symptoms:

CHEST PAIN PALPITATION SHORTNESS OF BREATH OTHER: _____

b) What triggers the symptoms?

EXERTION EXERCISE EXCITEMENT STRAIN MEALS OTHER: _____

Date of first episode: _____ Date of last episode: _____ Frequency: _____ Duration: _____

c) Examinations:

RESTING ELECTROCARDIOGRAM STRESS ELECTROCARDIOGRAM THALLIUM STRESS TEST

ECHOCARDIOGRAM MAGNETIC RESONANCE OTHER: _____

Date: _____ Results: _____

d) Diagnosis: _____ Date: _____

e) Hospitalization? Yes No Surgery? Yes No

If yes, details: _____ Date: _____

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

g) Past or future follow-up examinations? Yes No If yes, details: _____ Date: _____

h) Complete recovery? Yes No If yes, indicate since when: _____

i) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____

j) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: _____

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

9 ARTHRITIS, RHEUMATISM, GOUT

Do you or have you ever suffered from arthritis, rheumatism or gout? Yes No

If yes, answer the following questions:

a) Nature of disorder: ARTHRITIS RHEUMATISM GOUT ARTHROSIS OTHER: _____

b) Site of the pain:

HAND ELBOW SHOULDER FOOT AND ANKLE KNEE

HIP VERTEBRAL COLUMN NECK OTHER: _____

c) Indicate the symptoms:

STIFFNESS OF THE JOINTS UPON AWAKENING REDNESS OF THE JOINTS SWELLING OF THE JOINTS

PAIN DURING MOVEMENT CRACKING OF THE JOINTS NODULES

FEVER SORE THROAT OTHER: _____

Date of first episode: _____ Date of last episode: _____ Frequency: _____

d) Treatments: INFILTRATION RADIOTHERAPY PHYSIOTHERAPY EXERCISE OTHER: _____

Date: _____ Frequency: _____

e) Hospitalization? Yes No Surgery? Yes No

If yes, details: _____ Date: _____ Results: _____

Were there any heart complications? Yes No If yes, details: _____ Date: _____

f) Medication prescribed (name): _____ Dosage: _____ Duration: _____

Current medication? Yes. Indicate which one: _____

No. Since when: _____

g) Complete recovery? Yes No If yes, indicate since when: _____

h) Disability or absence from work or school? Yes No If yes, dates: _____ Duration: _____

i) Name of the physician who treated you or who is currently treating you:

Last name: _____ First name: _____ Date of last consultation: _____

Name of the clinic or hospital consulted most often: _____

Address of the clinic or hospital:

Address: _____ City: _____

Province: _____ Postal code: _____ Phone: _____

SIGNATURE

I hereby declare that the above answers and statements form an integral part of my application to Industrial Alliance Insurance and Financial Services Inc., that they are complete and true, and that no circumstance which might affect the risk of insurance on my life has been concealed.

Signed at _____ on _____

Signature of the proposed insured