

Digestive Disorders Questionnaire



PLEASE PRINT

1 Name of Proposed Insured _____ Date of Birth _____

2 Please state your diagnosis. _____

3 When was this condition first diagnosed? _____

4 Have you had a barium study, upper or lower endoscopy or any other investigations? Yes No
(If "Yes," please provide details below.)

Type of test/investigation	Date	Results

5 Please answer the following regarding your symptoms:

(a) Please describe your symptoms: _____

(b) When did symptoms first occur? _____

(c) How frequently do symptoms occur? (i.e. how often in the last 12 months). _____

(d) When was the last occurrence of symptoms? _____

6 Have you had an operation for this condition or is an operation being considered? Yes No
(If "Yes," please provide details below.)

(a)

Date	Type of Surgery	Name and address of Hospital	Name of Consultant and/or Surgeon

(b) Have you experienced any problems or complications following surgery? Yes No
 If "Yes," please provide details: _____

(c) Have you been discharged from follow-up? Yes No
 If "Yes," please state when: _____

7 Please provide details below of your medical treatment(s):

Medication Name (Copy from Pharmacy label)	Date last taken	Dosage/Frequency

(Continued on next page)

8 Regarding the medical follow-up of your condition:

(a) Who is the physician responsible for your follow-up? _____

(b) How frequently are you seen for follow-up? _____

(c) When was your last office visit? _____

9 Have you lost significant time (i.e. weeks) off work with this condition? Yes No
(If "Yes," please provide details below.)

Dates	Duration of time off work

10 Please provide any additional information on your condition which you feel will be helpful in processing your application.

11 Do you have any other major health impairments? Yes No
If "Yes," please provide details: _____

I hereby represent that all the statements and answers to the above questions are true and complete, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

Witnessed Signature of Proposed Insured

Date

Signature of Witness

Date