Desjardins Insurance
LIFE • HEALTH • RETIREMENT

95 St. Clair Avenue West
Toronto ON M4V 1N7

QUESTIONNAIRE FOR PULMONARY AND BRONCHIAL DISEASES

First name and last name	Date of birth			Reference number: Case ID, Policy no., Contract no. or Application no.
	Y	M	D	

1. From which pulmonary or bronchial disease(s) do you suffer?

☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Fibrosis ☐ Occupational lung disease ☐ Other

Additional details: _____

Date of initial symptoms: _____ (month/year) Date of diagnosis: _____ (month/year)

Frequency of attacks: _____ (times/year) Date of last attack: _____

2. Have you ever been:

hospitalized for this problem? ☐ Yes ☐ No treated at emergency? ☐ Yes ☐ No

If **Yes**, date(s): _____ Hospital: _____ Lenght of stay: _____

3. Have you ever consulted a respiratory disease specialist? ☐ Yes ☐ No

If yes, name: _____ Address: _____

Date: _____ Test performed: _____

4. Have you ever undergone respiratory tests? ☐ Yes ☐ No

If **Yes**, indicate the name of the test or tests, date, results, name of physician and/or hospital

_____

_____

_____

5. Have you ever missed work or school as a result of this respiratory problem? ☐ Yes ☐ No If **Yes**, date: _____ Duration: _____

6. Do you take medication? ☐ Yes ☐ No

If **Yes**: ☐ daily ☐ as required Name(s): _____

7. Have you ever taken cortisone in tablet form? ☐ Yes ☐ No If **Yes**, date: _____

8. Do you smoke? ☐ Yes ☐ No If **Yes**, number/day: _____

I declare that the answers given in this document are true and complete and I agree that they form an integral part of my application for insurance.

_____	_____	_____
Date	Signature of proposed insured (signature of father, mother or legal guardian, if minor)	Signature of witness