Equitable™
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RESPIRATORY QUESTIONNAIRE

Proposed Insured:	Date of Birth:	Application/Policy #:

1. Do you suffer or have a history of:

	Cause (allergic, occupational, tobacco-related, other)	Date of first episode	Date of last episode	Frequency per month	Frequency per year
Asthma					
Recurrent Bronchitis					
Emphysema					
Other:					

2. Have you ever been hospitalized or been seen in the emergency for the above? ☐ Yes ☐ No
   If Yes, state dates and duration of each episode:

3. Indicate names and addresses of all Doctor's and specialists consulted with applicable dates:

4. Have you ever undergone any tests (Pulmonary Function Tests, Chest X-rays, other)? ☐ Yes ☐ No
   If Yes, state dates, types and results:

5. Indicate all medications used (inhaled, oral, other):

	At time of flare-up	Maintenance Medications
Name		
Dosage		
Frequency		

6. Have you ever taken time off work for this condition? ☐ Yes ☐ No
   If Yes, specify date and amount of time off for each episode:

I declare that the above answers and statements are full, complete and true and shall form part of my application for insurance with Equitable®.

Date _____ Proposed Insured _____

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