

## Chest pain questionnaire

(by insured life)

Policy number

Member number\*

Group number\* (\*Fill in for FundsAtWork)

### 1: Details of insured life

Name of insured life	<input type="text"/>	Permanent identity number	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Permanent identity/passport number	<input type="text"/>	Telephone	<input type="text"/>	
Date of birth	<input type="text"/>	Financial adviser code	<input type="text"/>	
Financial adviser's name	<input type="text"/>	Telephone	<input type="text"/>	
Broker house code	<input type="text"/>			

### 2: General questions

1. Have you ever felt pain or discomfort in the chest? If Yes, did the pain or discomfort involve any of the following:  Yes  No

<input type="checkbox"/> The left shoulder, arm or hand	<input type="checkbox"/> The neck or jaw	<input type="checkbox"/> Both shoulders
<input type="checkbox"/> The middle of the chest	<input type="checkbox"/> The left side of the chest	<input type="checkbox"/> Other

If "other", provide full details:

2. Was the nature of the pain or discomfort:

<input type="checkbox"/> Pressure or constriction	<input type="checkbox"/> A stabbing pain	<input type="checkbox"/> A burning feeling	<input type="checkbox"/> A sharp pain
<input type="checkbox"/> An ulcer	<input type="checkbox"/> Other		

If "other", provide full details:

3. Was the pain or discomfort brought on by any of the following?

<input type="checkbox"/> Exercise	<input type="checkbox"/> Excitement	<input type="checkbox"/> Exertion	<input type="checkbox"/> Strain or stress	<input type="checkbox"/> Other
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If "other", provide full details:

4. Did the pain or discomfort occur at rest?  Yes  No

If "yes", indicate when it occurred:  During the night  After eating  Other

If "other", provide full details:

5. When was the first attack?

When was the last attack?

What was the average duration of the pain or discomfort?  min

How frequently do these attacks occur?

6. During or after experiencing the pain or discomfort, did you:

<input type="checkbox"/> Consult your doctor	<input type="checkbox"/> Have emergency treatment	<input type="checkbox"/> Go to hospital
<input type="checkbox"/> See a specialist	<input type="checkbox"/> Other	

If "other", provide full details:

## 2: General questions (continued)

7. Have you ever been prescribed medication for the pain or discomfort?  Yes  No

If "yes", provide the following information:

Type of medication	<input type="text"/>						
Dosage	<input type="text"/>	Date used	<input type="text"/>				
Type of medication	<input type="text"/>						
Dosage	<input type="text"/>	Date used	<input type="text"/>				
Type of medication	<input type="text"/>						
Dosage	<input type="text"/>	Date used	<input type="text"/>				

8. Was the diagnosis made by the doctor?  Yes  No

If "yes", was it any of the following:

Muscular/Skeletal problem	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Angina	<input type="checkbox"/>	Stomach complaint	<input type="checkbox"/>
Respiratory problem	<input type="checkbox"/>	Other	<input type="checkbox"/>				

If "other", provide full details:

9. How much physical activity are you allowed?  Full activity  Restricted activity

If restricted, please provide date when you may resume full activity

10. Has an electrocardiogram (ECG) or a chest X-ray ever been taken?  Yes  No

If "yes", provide date of the most recent test

11. Provide any further relevant details, including the name(s) and address(es) of the doctors/specialists and/or cardiologists who attended to you:

<input type="text"/>							
Name of medical doctor	<input type="text"/>						
Postal address	<input type="text"/>						
	<input type="text"/>	Postal code	<input type="text"/>				
Name of medical doctor	<input type="text"/>						
Postal address	<input type="text"/>						
	<input type="text"/>	Postal code	<input type="text"/>				
Name of medical doctor	<input type="text"/>						
Postal address	<input type="text"/>						
	<input type="text"/>	Postal code	<input type="text"/>				

## 3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

<b>Signature of insured life</b>	<input type="text"/>	<b>Date</b>	<input type="text"/>						
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No payment for the completion of this questionnaire.