BMO Insurance

RESET PRINT

BMO Life Assurance Company
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HEADACHE QUESTIONNAIRE (to be completed by Proposed Insured)

Name: _____ Application No.: _____

1. When did headache first occur? _____ When was the last attack? _____
2. How often do they occur? _____
3. Are they: ☐ Intermittent ☐ Continuous ☐ Brief ☐ Prolonged
4. Which part of the head is usually affected: ☐ Front ☐ Top ☐ Back ☐ Sides
5. Are there any associated symptoms or signs affecting:
   - ☐ Vision, visual fields, double vision
   - ☐ Numbness, tingling
   - ☐ Muscle weakness
   - ☐ Nausea, vomiting
   - ☐ Dizziness, hearing loss
   - ☐ Unsteadiness of gait or limbs, staggering
   - ☐ Undue sleepiness
   - ☐ Kidney disorder
   - ☐ Fits
   - ☐ High blood pressure
6. Is there any relationship between headache and
   - ☐ Nervous system
   - ☐ Medications
   - ☐ Allergies
   - ☐ Menstrual cycle (Female only)
7. Have any special diagnostic tests been done or recommended to the above? ☐ Yes ☐ No
   If yes, give date, doctor's name and description:
8. What diagnoses have been made? _____
9. What treatment have been prescribed? _____
10. Please provide details of doctors consulted regarding headache:

Name	Address	Dates

I declare that all answers to the questions in this questionnaire and statements made are true and complete and will form part of my application for insurance with BMO Life Assurance Company. I understand that if I do not completely and truthfully answer all of the questions, the company may void the policy.

Province Signed	Date (DD/MMM/YYYY)	Signature
		Proposed Insured X