

**CHEST PAIN/CHEST DISCOMFORT QUESTIONNAIRE** (to be completed by Proposed Insured)

Name: \_\_\_\_\_ Application No.: \_\_\_\_\_

1. Frequency of episodes of discomfort with approximate dates which relates to your history:

I have had only one episode which occurred on (give dates): \_\_\_\_\_

I have had \_\_\_\_\_ episodes which occurred on (give dates): \_\_\_\_\_

Episodes have been of a recurring nature.

First episode occurred on (give date): \_\_\_\_\_ Last episode occurred on (give date): \_\_\_\_\_

Frequency (per day, week or month): \_\_\_\_\_ Discomfort typically occurs:  during exercise  when at rest

**N.B. Questions 2 to 6 are to be answered as relating to a single episode, or to a typical episode if there have been many.**

2. a) Describe location of discomfort relative to the breast-bone, e.g. left of breast-bone, right of breast-bone, directly under breast-bone, in region of nipple, etc.: \_\_\_\_\_

b) In the diagram below, shade in the area corresponding to the location and the extent of the discomfort.

3. State whether pain or discomfort radiated to other regions, e.g. arm, neck, jaw etc.: \_\_\_\_\_

4. Describe the character and severity of the discomfort, by checking the appropriate descriptive terms.  Squeezing  Knife-like  Aching  
 Constricting  Stinging  Burning  Other: \_\_\_\_\_

5. Was there:  Shortness of Breath  Vomiting  Sensation of Fear?

6. How long a period did the discomfort last? \_\_\_\_\_

7. Did it necessitate cessation of activity on any occasion?  Yes  No  
 If yes, when and for how long a period? \_\_\_\_\_

8. a) Were you informed of the nature of the trouble?  Yes  No  
 If yes, give details: \_\_\_\_\_

b) Were you advised to follow any treatment or to modify your habits of living?  Yes  No  
 If yes, give details: \_\_\_\_\_

9. a) Were any electrocardiograms made?  Yes  No  
 If yes, when and by whom? \_\_\_\_\_

b) What is your understanding of the results? \_\_\_\_\_

10. a) What are your daily habits as regards smoking?  Cigarettes (approx. \_\_\_\_\_ per day)  Pipe or Cigar  Non-smoker

b) During your adult life, have your smoking habits changed substantially?  Yes  No  
 If yes, give details: \_\_\_\_\_

11. Name and Address of Physicians Consulted for Pain or Discomfort

Dates Consulted

_____	_____
_____	_____
_____	_____

I hereby agree that the foregoing questions and answers shall form part of the application for insurance made by me to BMO Life Assurance Company on the \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_ ; and they shall be of the same effect as if contained in the original application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ of \_\_\_\_\_ 20 \_\_\_\_\_

Witness

Proposed Insured