

**Identification**Policy number: Name of person to be insured: First Name of person to be insured: Date of birth:  /  /   
year / month / day**Section Musculoskeletal disorders**

1. Check all illness or conditions that you suffer from or cause your pain:

 Arthritis  Arthrosis  Rheumatism  Other \_\_\_\_\_2. Check all body regions affected:  Neck  Spine  Wrists  Hands  Shoulders  Hips  Knees  Ankles  Feet Other: \_\_\_\_\_3. Are the affected regions deformed?  Yes  No4. When did you first suffer from this illness?  /  /   
year / month / day

a) Frequency of episodes: \_\_\_\_\_

b) Average duration of episodes: \_\_\_\_\_

c) Date of most recent episode:  /  /   
year / month / day5. Are your job duties or daily activities restricted in any way because of this condition?  Yes  NoIf yes, describe restrictions and limitations: \_\_\_\_\_  
\_\_\_\_\_

