HUMANIA ASSURANCE MD®

# Chest pain Questionnaire

## Identification

Policy:

Last name of person to be insured:

First name of person to be insured:

Date of birth: year / month / day

## Section Chest pain

1. Have you ever suffered from chest pain? Yes ☐ No ☐

Date of first episode: year / month / day Date of last episode: year / month / day

Lenght of time between episodes: ______ Average duration: ______

2. If you answered yes to question # 1, where was the pain located?

☐ Center of chest? ☐ Both shoulders or arms? ☐ Left side of chest?

☐ Accompanied by a pressure? ☐ Shoulder, arm or left hand? ☐ Accompanied by perspiration?

3. Did you feel pain:

☐ On exertion or exercising? ☐ When experiencing a strong emotion?

☐ When exposed to cold temperature? ☐ After meals?

4. Did you consult a physician for the pain? Yes ☐ No ☐

If yes, type of treatment prescribed: ______

What type of medication are you currently taking for the pain? ______

How long after taking your medication is the pain relieved? ______



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## Chest pain (suite)

5. a) Have you ever stopped working because of the pain? Yes ☐ No ☐

Date you stopped working: ____ year / __ month / __ day Date you returned to work: ____ year / __ month / __ day

b) Were you ever hospitalized for this condition Yes ☐ No ☐

From: ____ year / __ month / __ day To: ____ year / __ month / __ day

Name of the hospital: ______

c) How long was your convalescence?

From: ____ year / __ month / __ day To: ____ year / __ month / __ day

d) Have you changed your lifestyle or your work duties because of this condition? Yes ☐ No ☐

Details: ______

e) How many hours do you work daily? ______

6. What was the diagnosis of your chest pain? ______

7. Have you ever suffered from: If yes, specify dates and doctors consulted:

Palpitations? Yes ☐ No ☐ ____ year / __ month / __ day Name: ______

Shortness of breath? Yes ☐ No ☐ ____ year / __ month / __ day Name: ______

High blood pressure? Yes ☐ No ☐ ____ year / __ month / __ day Name: ______

Specify names and addresses of all physicians consulted (not mentioned above): ______

## Chest pain (...continued)

9. a) Do you use tobacco products? Yes ☐ No ☐

If yes, type and daily use: ______________________

b) Have you ever used any tobacco products? Yes ☐ No ☐

If yes, when did you last use tobacco? ______________________

I, the undersigned, declare that the above answers are true and complete and shall from part of my application for insurance with Humania Assurance Inc.

Signed at: ______________________ Date: ☐☐☐☐ / ☐☐ / ☐☐
year / month / day

Signature of person to be insured: ______________________

Signature of witness: ______________________

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