Chest Pain History Questionnaire

Application Reference Number

The questionnaire must be completed by the Life Insured.

Important: No compensation is payable if a Medical Examiner completes this questionnaire.

Particulars of Life Insured

First Name(s)

Last Name

Identity No./Passport No. Compulsory

Date of birth dd/mm/yyyy

Address

Information regarding condition

1 Have you ever felt pain or discomfort in the chest? ☐ Yes ☐ No

a) If you have answered 'Yes', where did you experience this pain?

b) What was the nature of the pain or discomfort? For example, would you describe it as a vice-like ache, a dull, burning, stabbing or knife-like pain?

2 How often do you experience this pain or discomfort?

b) When did you last experience it? Please state the date.

c) What is the average duration?

3 Does the pain or discomfort occur only due to effort or exercise? ☐ Yes ☐ No

If you have answered 'Yes', do you feel compelled to stop the effort or exercise? ☐ Yes ☐ No

If the pain or discomfort is also experienced when you are at rest, state the time of day it arises.

4 Do you obtain relief from pain by taking medication? ☐ Yes ☐ No

If you have answered 'Yes', how soon does relief occur?

Please name the medication and provide further details.

5 Please describe how you behaved after you had experienced the chest pain or discomfort.

6 Did you immediately call a general practitioner or physician? ☐ Yes ☐ No

If you have answered 'Yes', please provide the name and address of general practitioner or doctor.

7 Were you taken to hospital? ☐ Yes ☐ No

If so, please provide the name and address of the hospital.

What form of treatment or instructions were given to you?

If treatment was given, please state the date, type and duration.

8 How much activity are you allowed currently:

- at work
- as sport?

If level of activity is restricted, please supply further information:

9 Has an ECG or X-ray of the chest been carried out or have blood tests been administered? ☐ Yes ☐ No

If 'Yes', please state the most recent date of the following:

- ECG dd/mm/yyyy
- X-ray of the chest dd/mm/yyyy
- Blood tests dd/mm/yyyy

10 Please state any further relevant information in the space below.

Declaration by Life Insured

I declare that the above information is true, complete and precise, and I agree that, together with the Proposal of Insurance, it shall form the basis of the Contract of Insurance.

Signature

Date dd/mm/yyyy

If you require any further details, please ask your financial adviser.
Alternatively you can contact your nearest Unilife office, details of which are available on our website, or get in touch using our email address:
administration@unihealthandlife.com