

Stomach Disorder Questionnaire

Last Name: _____ First Name: _____
Please Print

Date of Birth: _____ Policy/Application Number: _____

1. Please state the precise diagnosis, or nature of the condition you are suffering from (e.g. Barrett's esophagus, duodenal ulcer, gastro-esophageal reflux, indigestion, irritable bowel syndrome, hiatus hernia etc.) and attach a copy of any medical reports if available.

--

2. When was the condition diagnosed or when did you first experience symptoms?

/	/
---	---

3. Please describe your symptoms:

--

4. How often do you typically experience symptoms:

--

5. Are the symptoms becoming: ☐ more frequent ☐ less frequent ☐ unchanged

6. Are you aware of anything that precipitates your symptoms? ☐ Yes ☐ No

If yes, please provide details:

--

7. When did you last experience symptoms?

/	/
---	---

8. Do you currently take any medication for this condition?

☐ Yes ☐ No

If yes, please provide details:

Name of medication	Dose	Frequency

9. Other than already stated above, have you taken any other medication or had any other treatment in the past for this condition? ☐ Yes ☐ No

If yes, please provide details:

Name of medication or treatment	Dose	Frequency	Date last taken

10. Have you ever had any tests or investigations for this condition e.g. barium meal, colonoscopy, endoscopy, gastroscopy, ultrasound etc.? ☐ Yes ☐ No

If yes, please provide details:

Name of test or investigation	Location	Date	Result

11. Have you ever been admitted to hospital for this condition? ☐ Yes ☐ No

If yes, please provide details:

Name of doctor, hospital or clinic	Address	Dates

12. Has any further treatment or investigation been discussed or contemplated? ☐ Yes ☐ No

If yes, please provide details:

--

13. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Date of last consult

14. Have you ever taken time off work with this condition? ☐ Yes ☐ No

If yes, please provide dates and durations:

--

15. Have your working duties ever been affected or restricted in any way? ☐ Yes ☐ No

If yes, please provide details including dates and durations:

--

16. Please provide any additional information that you feel is important:

--

--

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

--

Name

x

Signature

/ /

Date