

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

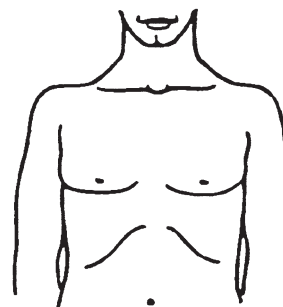
N.B. Questions 2 to 6 are to be answered as relating to a single episode, or to a typical episode if there have been many.

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