BMO Insurance

BMO Life Assurance Company
60 Yonge Street, Toronto, ON M5E 1H5
1-877-742-5244 • 416-596-4143 Fax

HEADACHE QUESTIONNAIRE (to be completed by Proposed Insured)

Name: _____ Application No.: _____

1. When did headache first occur? _____ When was the last attack? _____

2. How often do they occur? _____

3. Are they: ☐ Intermittent ☐ Continuous ☐ Brief ☐ Prolonged

4. Which part of the head is usually affected: ☐ Front ☐ Top ☐ Back ☐ Sides

5. Are there any associated symptoms or signs affecting:

   ☐ Vision, visual fields, double vision
   ☐ Numbness, tingling
   ☐ Muscle weakness
   ☐ Nausea, vomiting
   ☐ Dizziness, hearing loss
   ☐ Unsteadiness of gait or limbs, staggering
   ☐ Undue sleepiness
   ☐ Kidney disorder
   ☐ Fits
   ☐ High blood pressure

6. Is there any relationship between headache and

   ☐ Nervous system
   ☐ Allergies
   ☐ Medications
   ☐ Menstrual cycle (Female only)

7. Have any special diagnostic tests been done or recommended to the above? ☐ Yes ☐ No
   If yes, give date, doctor's name and description:

   _____

8. What diagnoses have been made? _____

9. What treatment have been prescribed? _____

10. Please provide details of doctors consulted regarding headache:

Name	Address	Dates
		dd/mm/yyyy

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