

ASTHMA, BRONCHITIS AND OTHER RESPIRATORY DISORDERS QUESTIONNAIRE

1. YOUR DETAILS

Full Name (Mr/Mrs/Miss/Ms/other)

Date of birth (DD MM YYYY)

Policy Number

2. YOUR HEALTH DETAILS

Please confirm the name of your condition
(asthma, bronchitis, COPD etc).

*You don't need to tell us about one-off chest
infections that you have fully recovered from.*

Which of the following best describes the frequency
of your symptoms?

☐

regularly have days with no symptoms or breathlessness

☐

symptoms of breathlessness each day, but with periods of respite

☐

continuous or most of the day

Please confirm all of your current treatment.

How many courses of steroid tablets have you taken
in the last 2 years (e.g. prednisolone)?

☐

0

☐

1-2

☐

More than 2

☐

Continuous

Please provide your latest Peak Expiratory Flow Rate
(PFR), if known.

Have you been admitted to hospital?

If so, please confirm dates

Please indicate which of the following best describe
the effect your symptoms have on performing your
normal occupation duties or normal daily activities.

☐

no effect

☐

some restriction on activities

☐

severe restriction on activities

Have you needed any time off work?

If so, please confirm how much and dates

3. DECLARATION

- I declare that the above information is true and complete to the best of my knowledge and belief.
- I understand that this shall form part of my application with my Scottish Widows plan as stated in section 1 of this questionnaire.

Signature

Date (DD MM YYYY)

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