QUESTIONNAIRE – DIGESTIVE SYSTEM DISEASES

SSQ, Life Insurance Company Inc.
1225 Saint-Charles Street West, Suite 200, Longueuil, Quebec J4K 0B9

GENERAL INFORMATION		
NAME	DATE OF BIRTH	CONTRACT NUMBER

I – MEDICAL HISTORY

1. Symptoms: ☐ Weight loss ☐ Haemorrhage ☐ Abdominal pain ☐ Constipation
   ☐ Vomiting ☐ Diarrhea ☐ Blood in vomit
   ☐ Blood in stool ☐ Black stool ☐ Other (specify): _____
2. Date of first symptom: _____ Duration: _____
3. Frequency of episode: _____
4. Exams performed: ☐ Ultrasound ☐ Laparascopy ☐ Endoscopy/Sigmoidoscopy
   ☐ Barium enema ☐ Other (specify): _____
   Date : _____ Results: _____
5. Medical diagnosis: ☐ Ulcer (specify): _____ ☐ Colitis (specify): _____
   ☐ Diverticulitis ☐ Polyp ☐ Other (specify): _____

II – TREATMENTS

1. Medication prescribed (dosage): _____
   _____
2. Currently under medication: ☐ No ☐ Yes (specify): _____
3. Diet: ☐ No ☐ Yes (specify): _____
4. Hospitalization: ☐ No ☐ Yes (reason): _____ Date: _____
5. Surgery: ☐ No ☐ Yes (specify): _____ Date: _____
6. Surgery to be scheduled: ☐ No ☐ Yes (specify): _____ Date: _____

III – DISABILITY

1. Leave of absence: ☐ No ☐ Yes Date: _____ Duration: _____
2. Disability period: ☐ No ☐ Yes Date: _____ Duration: _____
3. Current condition: _____
   _____

IV – ATTENDING PHYSICIAN

1. Name and address of physician who has your complete file: _____
   _____
2. Date of last visit: _____ Results: _____

V – ADDITIONAL INFORMATION CONCERNING YOUR CONDITION

_____
_____

I acknowledge having read and understood all the questions above and having given the correct answers. In addition, I consent to having them serve as the basis of the insurance contract requested.

Signature of witness	Date	Signature of the person to be insured or to be co-insured. If under age 18, signature of father or mother required.