Questionnaire
Musculoskeletal disorders

First and last names of insured ______________________________

Y Y Y Y | M M | D D
Date of birth

Policy / application number ______________________________

1. a) What is the nature of the musculoskeletal disorders?

☐ Tendonitis ☐ Sprain ☐ Ligament / Meniscus tear ☐ Carpal tunnel Syndrome
☐ Bursitis ☐ Epicondylitis ☐ Fracture ☐ Arthrosis
☐ Arthritis ☐ Joint replacement ☐ Osteoporosis / Osteopenia ☐ Fibromyalgia
☐ Other (specify): ______________________________
☐ Muscular dystrophy: date of diagnosis: Y Y Y Y | M M and type: ______________ (step to question 6)

b) What is the affected body part?

Area	Right	Left	Condition	Date of first symptoms
Shoulder	☐	☐		Y Y Y Y | M M
Elbow	☐	☐		Y Y Y Y | M M
Wrist	☐	☐		Y Y Y Y | M M
Hand	☐	☐		Y Y Y Y | M M
Hip	☐	☐		Y Y Y Y | M M
Knee	☐	☐		Y Y Y Y | M M
Ankle	☐	☐		Y Y Y Y | M M
Foot	☐	☐		Y Y Y Y | M M
Other, specify: ____________	☐	☐		Y Y Y Y | M M

2. Is there a known cause? ☐ Yes ☐ No

If yes, specify:

Condition	Cause
	☐ Accident ☐ Sports practice ☐ Repetitive movements ☐ Other (specify):
	☐ Accident ☐ Sports practice ☐ Repetitive movements ☐ Other (specify):
	☐ Accident ☐ Sports practice ☐ Repetitive movements ☐ Other (specify):

3. Have you consulted or will you consult doctors or therapists for any of the conditions mentioned above?

☐ Yes ☐ No

If yes, complete the information below:

Condition: ______________________________

Profession: ______________________________

Name and specialty: ______________________________

Address: ______________________________

Date of first consultation: Y Y Y Y | M M

Date of last consultation: Y Y Y Y | M M Results: ______________

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y | M M or ☐ No more consultation to come

3. Have you consulted or will you consult doctors or therapists for any of the conditions mentioned above? (continued)

Condition:

Profession:

Name and specialty:

Address:

Date of first consultation: Y Y Y Y M M

Date of last consultation: Y Y Y Y M M Results:

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y M M or ☐ No more consultation to come

Condition:

Profession:

Name and specialty:

Address:

Date of first consultation: Y Y Y Y M M

Date of last consultation: Y Y Y Y M M Results:

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y M M or ☐ No more consultation to come

4. Have any tests or examinations been done? ☐ Yes ☐ No

If yes, specify:

Test / examination	Condition	Results	Date
☐ MRI			Y Y Y Y M M
☐ X-Ray			Y Y Y Y M M
☐ Scan			Y Y Y Y M M
☐ Blood test			Y Y Y Y M M
☐ Other: ____________			Y Y Y Y M M

5. Have any tests, examinations or treatment been recommended that have not yet taken place? ☐ Yes ☐ No

If yes, specify the condition, type of test, examination or treatment and anticipated date.

Date: Y Y Y Y M M

Date: Y Y Y Y M M

6. Are you taking or have you taken medication(s) for any of the conditions mentioned above? ☐ Yes ☐ No

If yes, specify:

Condition:

Medication: Dosage:

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

Condition:

Medication: Dosage:

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

Condition:

Medication: Dosage:

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

7. Have you undergone or have you been advised to undergo surgery for any of the conditions mentioned above?
☐ **Yes** ☐ **No**

If yes, specify:

Type of surgery	Condition	Date
		Y Y Y Y M M
		Y Y Y Y M M
		Y Y Y Y M M

8. Do you have limitations in your activities of daily living, in your work schedule or in your leisure time because of any of the conditions mentioned above? ☐ **Yes** ☐ **No**

If yes, specify the condition and limitations: ______________________________

9. Have you had to take time off work / school because of any of the conditions mentioned above? ☐ **Yes** ☐ **No**

If yes, specify:

Condition	Start date	Duration (in weeks)
	Y Y Y Y M M	
	Y Y Y Y M M	
	Y Y Y Y M M	

10. What is your current state?

Specify:

Condition	Current state
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:

11. Additional information

____

12. Declaration

I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.

X ______________________________ Y Y Y Y M M D D

Signature of insured (signature of the father, mother or legal guardian if the insured is a minor) Date of signature