UV INSURANCE

NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

HEADACHE QUESTIONNAIRE

1. **When did the first headache occur:** _____ **When was the last attack:** _____
2. **Frequency:** _____
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?**
   - a) Vision, visual fields and double vision: _____
   - b) Numbness, tingling: _____
   - c) Muscle weakness: _____
   - d) Nausea, vomiting: _____
   - e) Dizziness, hearing loss: _____
   - f) Unsteadiness of gait or limbs, staggering: _____
   - g) Undo sleepiness: _____
   - h) Kidney disorder: _____
   - i) Fits: _____
   - j) High blood pressure: _____
6. **Is there any relationship between headache and**
   - a) Nervous system: _____
   - b) Allergies: _____
   - c) Medications: _____
   - d) Menstrual cycle (female only): _____
7. **Have you ever missed work because of this disorder?** Yes ☐ No ☐

   If yes, provide the duration and dates of leave: _____

   _____
8. **Have any special diagnostic tests been made or recommended?** Yes ☐ No ☐

   If yes, provide the date, name of physician, location and results? _____

   _____
9. **What diagnosis has been made?** _____
10. **What treatment has been prescribed?** _____
11. **Name(s) and address(es) of all the consulted physician(s):** _____

    _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____

SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____

WITNESS **DATE**

P.O. Box 696, Drummondville (Quebec) J2B 6W9 ■ Phone: 819 478-1315 ■ Toll free: 1 800 567-0988 ■ Fax: 819 474-1990