Policy Number

BRONCHIAL ASTHMA QUESTIONNAIRE - Applicant
(To form part of the policy contract)

Name of Applicant: _____

1. When was the first asthma attack experienced? _____

2. How often do you have attacks? ◯ weekly ◯ monthly ◯ yearly ◯ others _____

3. What triggers your asthma attacks?

◯ dust / pollution ◯ food ◯ exercise
◯ change in climate ◯ respiratory infection ◯ others (please specify) _____

4. Do you experience asthma attack at night? ◯ YES, please provide details below ◯ NO

If yes, how often in a month? _____

5. a. When was your last asthma attack? _____

b. Was medical consultation sought? ◯ YES, please provide details below ◯ NO

If yes, when? _____ Name of Attending Physician _____

6. a. Are you taking medication for this condition? ◯ YES, please provide details below ◯ NO

Date Prescribed (mm/dd/year)	Name of Medication	Dosage	Date Medication Stopped (mm/dd/year) and Reason/s
/ /			
/ /			
/ /			

b. Do you use nebulizer/s as part of routine maintenance for asthma? ◯ Yes ◯ No

7. Have you been admitted to a hospital/facility due to this condition?

◯ YES, please provide details below ◯ NO

Date Admitted (mm/dd/year)	Date Discharged (mm/dd/year)	Name of Hospital/Facility	Reason for Confinement
/ /	/ /		
/ /	/ /		

8. Have you ever had, or do you currently suffer from any of the following? ◯ Yes ◯ No

Please Check	Other Associated Conditions	Date of last Episode/Attack
◯ Yes ◯ No	Chronic Bronchitis	/ /
◯ Yes ◯ No	Cor Pulmonale or Cardiac Arrest	/ /
◯ Yes ◯ No	COVID-19	/ /
◯ Yes ◯ No	Emphysema or Chronic Obstructive Pulmonary Disease (COPD)	/ /
◯ Yes ◯ No	Status Asthmaticus or Extreme Asthma Emergency	/ /
◯ Yes ◯ No	ICU confinement in the last 5 years	/ /
◯ Yes ◯ No	Others:	/ /

9. Have you taken time off work (or school, if applicable) due to asthma? ◯ YES, provide details ◯ NO

Reason for time-off: _____

Date/s of time-off: _____

10. Give the full name, address and contact no. of your regular attending physician.

Name of Attending Physician:	Specialization:
Contact Number:	Email Address:
Clinic Address	

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance.

_____ _____

*Name and Signature Date of Signing

**To be completed and signed by the Proposed Owner if application is for a Minor.*

AXA PHILIPPINES

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