RBC Insurance®

Gastrointestinal Disorder Questionnaire

Name of Proposed Insured: ______________________ **Application/Policy No:** ______________

1. Do you have or have you ever suffered from any of the following (check appropriate box): ☐ Stomach Disorder ☐ Gastric Ulcer ☐ Peptic Ulcer ☐ Oesophageal Disorder ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Intestinal Disorder ☐ Other **If 'other'**, please specify (include diagnosis and date of diagnosis, if known): ______________________

2. Describe all symptoms in the past 12 months: ______________________

3. Do you have or have you ever had: ☐ A hemorrhage? ☐ Passing of black stools or blood? ☐ Vomiting? ☐ Other symptoms (e.g. diarrhea, fatigue, etc)?
   If other symptoms, please provide details: ______________________

4. a) Date of onset of symptoms: ______________________
   b) Date symptoms last occurred: ______________________
   c) How often do symptoms occur? ______________________
   d) How long do symptoms last? ______________________

5. Have you lost weight within the last two years? ☐ Yes ☐ No **If yes**, please indicate how much and cause of weight loss: ______________________

6. a) Have any tests or investigations been completed? ☐ Yes ☐ No **If yes,** please specify type, date and results:
   ☐ Gastroscopy: ______________________
   ☐ Endoscopy: ______________________
   ☐ Colonoscopy: ______________________
   ☐ Sigmoidoscopy: ______________________
   ☐ X-ray studies: ______________________
   ☐ Other, specify: ______________________

   b) Have any tests or investigations been recommend? ☐ Yes ☐ No **If yes**, please specify nature of test or investigation and date scheduled: ______________________

7. a) Have you ever had any surgery(ies) for this condition? ☐ Yes ☐ No **If yes**, please specify date(s), name of hospital and nature of surgery(ies): ______________________

   b) Have you been told you may need surgery in the future? ☐ Yes ☐ No **If yes**, please specify the type of surgery and date if already scheduled: ______________________

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8. Other than indicated in no. 7a), have you ever been hospitalized for this condition? ☐ Yes ☐ No
   If yes, please advise date(s), reason(s) and name and address of hospital(s): ______________________

9. Are you currently taking any medication on a regular or an as needed basis? ☐ Yes ☐ No
   If yes, please indicate name(s), dosage(s), and frequency of medication(s): ______________________

10. Have you ever lost time from work due to this condition? ☐ Yes ☐ No **If yes**, provide details including dates and duration of each period of absence from work: ______________________

11. Are your job duties or daily activities restricted in any way because of this condition? ☐ Yes ☐ No
    If yes, please describe restrictions or limitations: ______________________

12. Please provide full names and addresses of all other doctors, health care practitioners, hospitals or health care facilities consulted for this condition and provide the dates of consultations: ______________________

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: ______________________ **Date:** ______________________
Day/Month/Year

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