



Name of Proposed Insured: _____ Application/Policy No: _____

1. Have you ever had or been told you had (tick off appropriate box(es): fainting spell
 concussion convulsion syncope other type of loss of consciousness
If other, specify type and describe symptoms: _____

2. What is your doctor's diagnosis and explanation of the cause (palpitation, low blood pressure, etc.)? _____

3. a) Date of first episode: _____ Month/Year b) Date of last episode: _____ Month/Year
c) Frequency of episodes: _____ d) How long does each episode last? _____

4. During episodes, is consciousness lost completely? Yes No **If yes**, for how long? _____

5. Do you have any aura or warning of an episode? Yes No **If yes**, please explain: _____

6. Have you been referred to a specialist for this condition? Yes No **If yes**, please provide full name(s) and addresses of specialist(s) consulted and frequency of follow-ups: _____

7. a) Was medication and/or treatment initially prescribed for this condition? Yes No
If yes, provide date and details of original treatment, name of medication, and date prescribed: _____

b) Are you currently taking any medication or receiving any treatment? Yes No
If yes, provide date and details of current treatment, name of medication, dosage and date prescribed: _____

8. Have any diagnostic tests been completed or recommended? Yes No **If yes**, please specify:
 EEG Skull x-ray CAT scan MRI ECG Heart monitor Blood vessel study
 Other (specify): _____
Specify date(s) and results for each test: _____

9. 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): _____



Loss of Consciousness Questionnaire

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10. Have you lost any time from work due to this condition? Yes No **If yes**, provide details including dates and duration of time off 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 the 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