CHEST PAIN QUESTIONNAIRE

(To be completed by the Life to be Insured)

Please check all details, then complete the relevant areas of the form and return it to:
BSP Health (Fiji) Limited, Level 5, BSP Life Centre, Thomson Street, Private Mail Bag, Suva, Fiji.
Telephone: 331 7000 Call Centre: 132 700 Facsimile: 330 8955 Web: www.bsplife.com.fj

	Full Name:		Date of Birth:	
	Proposal Number:		Dated:	

1.	Have you ever had chest pain or discomfort?	☐ No	☐ Yes
	▸ *If "Yes", please state:*		
	(i) Site of pain or discomfort, i.e. whether in the middle or on the left or right side of the chest, radiating to the left or right arm, or elsewhere.		
	(ii) Nature of pain or discomfort, i.e. vise-like, ache, burning, stabbing or knife-like pain.		
	(a) What was the date of the first attack?		
	(b) How frequently do these attacks occur?		
	(c) What was the date of the most recent attack?		
2.	What is the average duration of an attack?		
	(a) Do attacks occur only on exertion?	☐ No	☐ Yes
	If "Yes", must you stop the effort?	☐ No	☐ Yes
	(b) If attacks occur at rest, at what time of the day do they take place?		
	(c) Have you as far as you know received any of the following? ▸ *If "Yes", please give details of dosage and dates.*		

	Drug			Dosage	Date
	Trinitrates (to place under the tongue)	☐ No	☐ Yes		
	Treatment to cause thinning of the blood (e.g Warfarin, Aspirin)	☐ No	☐ Yes		
	Any other drugs	☐ No	☐ Yes		
	(d) Has any other medication ever been prescribed for your pain? ▸ *If "Yes", please state name of the drug and dosage.*			☐ No	☐ Yes

3.	How much physical activity are you allowed. (If restricted, please say so and give full details of resumption of activity)?	
	(a) At work:	
	(b) At sport:	
4.	Has an electrocardiogram or a chest X-ray or any other blood tests been done? ☐ No ☐ Yes ▸ *If "Yes", please state dates and results.*	

				Date	Result
	Chest X-Rayed	☐ No	☐ Yes		
	Lipids done (e.g. cholesterol).	☐ No	☐ Yes		
	Cardiac Enzymes	☐ No	☐ Yes		
	Blood tests	☐ No	☐ Yes		
	Electrocardiogram (ECG tracing)	☐ No	☐ Yes		

	(Please attach copies of the above tests if available)	
5.	Please state any further relevant particulars including name and address of personal medical attendant or attendants.	
	Name of Doctor:	
	Address:	

	Name of Doctor:	
	Address:	

	Name of Doctor:	
	Address:	

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

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

Signature of Life to be Insured	Signature:	Date:
		Signed at:
Signature of Witness	Name in Full	Date:
	Signature:	Signed at: