



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

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 _____ X _____
 WITNESS DATE