Manulife

ASTHMA QUESTIONNAIRE TO BE COMPLETED BY ATTENDING DOCTOR

Proposed life assured: _____ **Proposal No:** _____

NRIC No: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female**

We would appreciate if you could kindly complete this questionnaire

1. **For how long has the above-named been under your care for asthma?**

   _____

2. **Please indicate the P.E.F. determination on his/her first consultation at your clinic**

   _____ **L/Min**

3. **Does he/she use a peak flow meter at home?** ☐ **Yes** ☐ **No**

4. **How many times per year on an average does the above-named visit your clinic for the following**

   (a) Treatment of an attack of asthma?

   _____

   (b) Consultation for renewal of prescription for asthma?

   _____

5. **At what age did his/her asthma begin?**

   _____

6. **Does he/she suffer from concomitant C.O.A.D.?** ☐ **Yes** ☐ **No**

7. **Is his/her asthma related to any occupational exposure?** ☐ **Yes** ☐ **No**

8. **Does he/she smoke?** ☐ **Yes** ☐ **No**

   (a) No. of _____ smoked per day

9. **Does he/she have any history of atopy?** ☐ **Yes** ☐ **No**

10. **When did he/she have an acute attack?**

    _____

11. **What were his/her pre and post attack P.E.F. values ?**

    Pre attack: _____ **L/Min** **Post attack:** _____ **L/Min**

12. **How many acute attacks has he/she had in the last 24 months?**

    _____

13. **How many of these attacks required:**

    (a) attendance by a doctor?

    _____

    (b) admission to a hospital?

    _____

    (c) use of oral steroids?

    _____

    (d) absence from work?

    _____

14. **His/her asthma is treated by:**

    (a) use of bronchodilators continuously ☐

    (b) use of bronchodilators intermittently ☐

    (c) use of inhaled steroids ☐

    (d) use of oral steroids continuously ☐

    (e) use of oral steroids intermittently ☐

    (f) the use of inhalers as and when required only ☐

Version 042020

Manulife Insurance Berhad Registration No. 200801013654 (814942-M)
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15. Please indicate the preparation and dosage of oral steroids that he/she requires on a continuous basis for his/her treatment

_____

16. Please indicate the name of the preparation and dosage of the following if they are used in his/her treatment

TYPE OF MEDICATION	NAME OF PREPARATION	DOSAGE
(a) Oral bronchodilators		
(b) Bronchodilators by inhalation		
(c) Bronchodilators by suppository		
(d) Corticosteroids by inhalation		
(e) Sodium cromoglycate - Intal etc.		
(f) Other medication		

17. Is the above-named compliant with his/her treatment and medication? ☐ Yes ☐ No

18. Were any of the following done in the last 2 years?

TEST	YES	NO	DATE	RESULTS
(a) Chest X-ray				
(b) Pulmonary function test				
(c) Allergy				
(d) Others (Please Specify)				

19. Please note the last 3 P.E.F. determinations from your records

i) _____ L/Min ii) _____ L/Min iii) _____ L/Min

20. How would you best consider the control of his/her asthma?

(a) Very well controlled ☐ (b) Moderate control ☐ (c) Poor control ☐

This report has been prepared by:

_____ _____

Signature of Doctor Clinic Rubber Stamp

Name : _____

Telephone No. : _____

Dated : _____

Kindly return this Questionnaire in a sealed envelope to the underwriter of our Company so as to maintain confidentiality of the information provided.

(We thank you for completing this questionnaire)

Name of Underwriter: _____ Date: _____