

MAS, FREEPOST 884, PO Box 13042, Johnsonville, Wellington.
Phone 0800 800 627. Facsimile (04) 477 0109.

Asthma questionnaire

| | | | |
|---|--|--|---|
| i) Frequency of symptoms in the last five years | <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Occasionally |
| | <input type="checkbox"/> One-off episode | <input type="checkbox"/> None – childhood only | |
| ii) Severity of symptoms in the last five years | <input type="checkbox"/> Nil symptoms <input type="checkbox"/> Mild, e.g. exercise-induced only, seasonal (related to hayfever, colds or flu) <input type="checkbox"/> Moderate, e.g. all year round, no specific triggers <input type="checkbox"/> Severe, e.g. constant, reduced lung capacity, restriction of lifestyle or work duties | | |
| iii) Have you, over the last two years, required: | Daily preventative inhalers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Occasional use of nebuliser or oral steroid medication e.g. prednisone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Hospitalisation/emergency treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| iv) Maximum number of consecutive days off work/study you have had over the last two years due to this condition | <input type="text"/> | | Days |
| I <input type="text"/> acknowledge that the answers I have provided above are true and complete and form part of my application under policy <input type="text"/> | | | |
| Member Name | <input type="text"/> | <input type="checkbox"/> | (*Please type your name and tick the check box to verify the above information) |