BLUE CROSS®

Nervous Disorders Questionnaire

IDENTIFICATION

Name of insured: _____ Contract No.: _____

Principal ❒ Spouse ❒ Child ❒ Date of birth Y M D

INFORMATION

1. Please specify the date of the first symptoms of:
   - ❒ Fatigue Y M D
   - ❒ Depression Y M D
   - ❒ Insomnia Y M D
   - ❒ Nervousness/Anxiety Y M D
   - ❒ Weight loss Y M D
   - ❒ Other: _____ Y M D

   What was the cause of these symptoms? _____
2. Have you ever had suicidal thoughts? ❒ NO ❒ YES
3. Please check the activities that have been affected by this condition and give details:
   - ❒ No activity affected
   - ❒ Work Details: _____
   - ❒ Courses/School Details: _____
   - ❒ Work at home Details: _____
   - ❒ Social/Sports activities Details: _____
4. Period away from work, if any: From Y M D to Y M D ❒ NONE
5. Medical diagnosis made: _____
6. Name(s) and address(es) of physician(s) consulted: _____
7. Medication prescribed and suggested dosage: _____
8. Lenght of treatment: From Y M D to Y M D
9. Did this condition require hospitalization? ❒ NO ❒ YES
   If so: From Y M D to Y M D
   Name and address of hospital: _____
10. Have you ever been or are you in a complementary therapy with a physician, psychiatrist, psychologist or psychotherapist?
    ❒ NO ❒ Yes • Name and address of physician or therapist: _____
11. In the past six months, have you changed your medication? ❒ NO ❒ YES
    If so, specify the changes: _____
12. Have you completely recovered? ❒ NO ❒ Yes If so, since when? Y M D
13. Are you currently taking any medication? ❒ NO ❒ YES If so, please specify: _____
14. Are there other medical or therapeutic consultations foreseen? ❒ NO ❒ YES
    If so, please provide the dates and the length of time: _____
15. Have you had more than one episode? ❒ NO ❒ YES
    If so, please provide the dates, the length of time and the treatments: From Y M D to Y M D
    From Y M D to Y M D From Y M D to Y M D

DECLARATION

I acknowledge having read and understood the questions above and having given the correct answers. In addition, I consent to having them serve as the basis of the insurance contract requested.

Signature of witness (agent)	Date	Signature of person to be insured or the co-insured (if the person is under 18, signature of father or mother)