

## Additional questionnaire

as a supplement to the application resp. demand for an offer from: \_\_\_\_\_

(does not replace answering the health questions in the application resp. demand for an offer)

## Migraine/ Headache

**Incorrect or incomplete information may entitle us - depending on fault - to withdraw from the contract, to terminate it or to adjust it, which can lead to the insurer being released from performance - even for insured events that have already occurred. Please also note the “Information of the Consequences of the Violation of the Disclosure Obligation” in the application.**

**We ask you not to send us any results or data of genetic examinations or analysis!  
You only have to inform us of already existing complaints, pre-existing conditions, no matter by which examination methods you have acquired this information.**

What was the medical doctor's diagnosis for the disease?

- migraine (with or without aura)
  - tension headache
  - cluster headache
  - others, which ones?
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What complaints have you had, or do you have?

- eye flickering
  - vomiting, nausea
  - olfactory sensitivity or Noise sensitivity
  - headache
  - others, which ones?
  - light sensitivity
  - visual disturbances
  - dizziness
  - speech disorder
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Has a cause been identified?  yes  no

If "yes", which ones?

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Do you still have complaints today?  yes  no

If "yes", which ones?

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When did the complaints first occur and when did they last occur?

For the first time? \_\_\_\_\_ For the last time? \_\_\_\_\_

At what intervals do the complaints occur? \_\_\_\_\_ times a day \_\_\_\_\_ times a week

\_\_\_\_\_ times a month \_\_\_\_\_ times a year

How often do the complaints occur?

one-time  repeatedly  continuously  menstrual cycle dependent

How long do the complaints last? \_\_\_\_\_ hours

Could a space-occupying process be excluded  
(e.g. aneurysm, hemorrhage/bleeding, tumor, cyst)?  yes  no

If "no", what is it?

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What examinations have been performed so far?

- neurological examination when? \_\_\_\_\_
  - computer tomography (CT scan) when? \_\_\_\_\_
  - magnetic resonance tomography when? \_\_\_\_\_
  - others, which ones? \_\_\_\_\_
- \_\_\_\_\_ when? \_\_\_\_\_

What are the findings?

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**Please provide us with a copy of the treatment and findings reports!**

What therapeutic measures have been performed so far?

- acupuncture from \_\_\_\_\_ to \_\_\_\_\_
  - autogenous training from \_\_\_\_\_ to \_\_\_\_\_
  - physical therapy from \_\_\_\_\_ to \_\_\_\_\_
  - medication therapy (drug therapy) from \_\_\_\_\_ to \_\_\_\_\_
  - physical therapy from \_\_\_\_\_ to \_\_\_\_\_
  - others, which ones? \_\_\_\_\_
- \_\_\_\_\_

Are you taking any medication?  yes  no

If "yes", name? - dosage?

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("Dosage or how often a year and for how long do you need medication?": e.g. 12x a year over 3 days - 2 tablets per day)

When was your last treatment? \_\_\_\_\_

Are you free of treatments and complaints?  yes  no

If "yes", since when? \_\_\_\_\_

If "no", which complaints do you have? \_\_\_\_\_

Are further diagnostic and/or therapeutic measures necessary, intended or recommended?  yes  no

If "yes", which ones? \_\_\_\_\_

Which doctor can provide information? (Please provide name and address.) \_\_\_\_\_

Additional comments from the applicant or interested party:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Notice:** Please let us have the discharge, examination, treatment and findings reports available to you for a short time (if possible, a copy).

**Declaration**

The information provided on the questions has been answered correctly and completely to the best of our knowledge. I am solely responsible for the correctness of the information, even if I did not fill out the declaration myself. I have observed the information on the "Consequences of the Violation of the Disclosure Obligation" in the application.

Place/date

Signature of the applicant resp. interested party