Trust Financial Services
Your source for life solutions

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HYPERTENSION (High Blood Pressure) QUESTIONNAIRE

CLIENT: NAME ___________________________________ / ☐ M ☐ F / DOB _________ AGE _____ / HT _____ WT ____ / STATE _____

AMT. REQUESTED $ ______________ / MAX. ANNUAL PREMIUM $ _________________ / TYPE OF INS. ☐ UL ☐ TERM YRS. LVL ______

TOBACCO USE ☐ NO ☐ YES, TYPE _____________________ / REPLACEMENT ☐ YES ☐ NO / CURRENT ANN. PREM. $ ____________

LAST LIFE INSURANCE APP. YEAR _______ COMPANY ___________________________ ACTION __________________________________

OCCUPATION ____ / MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER ________ MOTHER _______ SIBLING 1 _______ SIBLING 2 ______ SIBLING 3 ______

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH ____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _______________ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS ___________

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☐ NO ☐ YES, DETAILS ____

DATE OF LAST MEDICAL CHECKUP ___________ / DATE OF LAST EKG ____________ AND RESULTS ____________________________

LAST BLOOD PRESSURE READING (RESULTS) ____________/___________ / ARE YOU TREATED FOR BLOOD PRESSURE ☐ NO ☐ YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) ____________, _____________ TREATED FOR CHOLESTEROL ☐ NO ☐ YES

AGENT: NAME ____ PHONE ______________________ FAX ___________________

ADDRESS ____ CITY ________________________ ST _____ ZIP __________

1. PLEASE DETAIL THE CLIENT'S FAMILY HISTORY (AGE IF LIVING / AGE AT THE TIME OF DEATH AND CAUSE):

FATHER _____/____

MOTHER _____/_______________________________________

SIBLING _____/____

SIBLING _____/____

2. CLIENT'S MEDICAL HISTORY (CHECK ALL THAT APPLY):
☐ CANCER HISTORY
☐ HEART HISTORY / CONDITION
☐ DIABETES HISTORY
☐ ALCOHOL OR DRUG ABUSE HISTORY
☐ HIGH BLOOD PRESSURE, PLEASE DETAIL:

CURRENT READING _________ / HIGHEST READING ________

TYPE OF TREATMENT __________________________________

☐ ELEVATED CHOLESTEROL HISTORY, PLEASE DETAIL:

CURRENT READING ______ / HDL READING OR RATIO _______

HIGHEST CHOLESTEROL READING ______________________

TYPE OF TREATMENT __________________________________

☐ ELECTORCARDIOGRAM (EKG), IF TAKEN W/IN PAST YEAR:

RESULTS: ☐ NORMAL ☐ OTHER ________________________

☐ STRESS EKG OR THALLIUM, IF TAKEN W/IN PAST YEAR:

RESULTS: ☐ NORMAL ☐ OTHER ________________________

☐ SIGMOIDOSCOPY, IF TAKEN W/IN PAST YEAR:

RESULTS: ☐ NORMAL ☐ OTHER ________________________

☐ PROSTATE EXAM, IF TAKEN W/IN PAST YEAR:

RESULTS: ☐ NORMAL ☐ OTHER ________________________

☐ MAMMOGRAM, IF TAKEN W/IN PAST YEAR:

RESULTS: ☐ NORMAL ☐ OTHER ________________________

3. HT _____ WT ____ / WT LOSS IN LAST YEAR __________

LAST MEASURED BODY FAT % ________ / DATE ____________

MEN ONLY: CHEST SIZE _______ IN. / WAIST SIZE _______ IN.

4. HAS THE CLIENT HAD A STANDARD MEDICAL CHECKUP W/IN THE PAST YEAR:

☐ NO ☐ YES, PLEASE DETAIL: ☐ NORMAL ☐ OTHER _______

5. LIST ANY OTHER ILLNESSES OR IMPAIREMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY:____

Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.

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