

PULMONARY DISEASE 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 NOTE TYPE OF LUNG DISEASE _____

- CHRONIC BRONCHITIS
- EMPHYSEMA
- RESTRICTIVE LUNG DISEASE
- ASTHMA

2. PLEASE NOTE DATE FIRST DIAGNOSED _____

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

NO YES, DATE _____

4. HAS THE CLIENT EVER SMOKED?

- YES, CURRENTLY SMOKES _____ (AMOUNT/DAY)
- YES, SMOKED IN THE PAST BUT QUIT _____ (DATE)
- NO, NEVER SMOKED

5. IS THE CLIENT ON ANY MEDICATION, AN INHALER, OR OXYGEN TANK FOR THE DISEASE?

NO YES, DETAILS _____

6. HAS THE CLIENT HAD A RECENT PULMONARY FUNCTION (BREATHING) TEST?

NO YES, RESULTS _____

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON AN ACG OR X-RAY?

NO YES, DETAIL _____

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

