

MEDICAL HISTORY QUESTIONNAIRE: COPD

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: _____ Coverage Information: _____

Never Type: Term UL IUL
 Former Date Stopped: _____ WL VUL Survivorship
 Current Type: _____ Face Amount: _____
Premium Tolerance: _____

Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis _____

2. What is the type of lung disease?

Chronic bronchitis Restrictive lung disease
 Emphysema Asthma

3. Has your client ever been hospitalized for this condition?

No Yes; please provide details:

4. Has your client ever smoked?

Yes, and currently smokes (amount per day): _____
 Yes, smoked in the past but quit (date quit): _____
 Never smoked

5. Have pulmonary function tests (a breathing test) ever been done?

No Yes; please provide details

6. Does your client have any abnormalities on an ECG or X-ray?

No Yes; please provide details

7. Please list current medications

Name of Medication	Dosage	Reason

8. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details:
