

MEDICAL HISTORY QUESTIONNAIRE: DEPRESSION

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

- Never
 Former
 Current

Date Stopped: _____
Type: _____

Coverage Information:

- Type: Term UL IUL
 WL VUL Survivorship

Face Amount: _____
Premium Tolerance: _____

Proposed Insured's Existing Insurance

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

1. Date of Diagnosis _____

2. Please indicate: Number of episodes: _____ Date of last episode: _____

3. Has the client been hospitalized for psychiatric treatment? No Yes

If yes, please provide details: _____

4. Does the client have a history of any of the following conditions? (check all that apply)

- Personality disorder Psychotic disorder Suicidal thought/attempt
 Substance abuse (alcohol or drugs, if yes, complete questionnaire)
 Other psychiatric disorder

If yes, please provide details: _____

5. Is the client currently working? No Yes

If yes, list occupation: _____

6. Has any time been lost from work as a result of condition? No Yes

If 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: _____