MEDICAL HISTORY QUESTIONNAIRE: DEPRESSION

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never

☐ Former Date Stopped: _____

☐ Current 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: