



Life Insurance Questionnaire

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Client Name _____ DOB _____ Height _____ Weight _____

Address _____ City _____ State/Zip _____

Phone _____ Fax _____ Cell _____ Email _____

Are you a US Citizen? _____

Have you ever used any form of tobacco? _____
If so, when _____ what _____

Date & reason of last doctor visit _____

Current Medications – list all taking along with the condition each prescribed for, length of time taken, frequency, and dosage.

For the following questions, if “Yes”, please provide details below.

Have you ever been treated or diagnosed with any of the following:

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> COPD | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> MS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Alcohol Abuse | |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression | |

Do you do any foreign travel? _____

Do you participate in flying (airplanes, helicopters, hot air balloons, etc.), scuba diving, or racing? _____

Have you ever been rated or declined for insurance? Why? _____

Has any member of your family (parent or sibling) been treated for cancer, heart disease, or any cardiac related condition prior to age 60? _____

Please provide details to any questions above. _____

