Name:______________________ DOB: __________________
Address:____________________________ Ht:____ft _____in
____________________________________ Wt: _________lbs
Phone #:________________ Sex: ☐ M ☐ F
Amount of Life Insurance Requested $___________________

MEDICAL QUESTIONNAIRE

Personal Information

Have you ever used any form of tobacco? ☐Yes ☐No If so please list Type_____________ and Date last Used ____/____/_____	
Confirmed plans to travel or reside outside of the United States or Canada in the next 2 years?	☐Yes ☐No
Within the past 3 years have you engaged in motorized racing, hang gliding, ballooning, sky-diving, flying as a pilot or crewmember, parachuting, mountain or rock climbing, skin or scuba diving, bungee jumping or other hazardous avocations? If Yes, give details on separate page.	☐Yes ☐No
Have you ever applied for insurance or policy reinstatement which was denied, rated, ridered or modified?	☐Yes ☐No
Are you currently pregnant? If so please list your Due Date _____/____/_____	☐Yes ☐No

Applicant's Medical Doctor's Information

Name: ___________________ Phone: _________________Address: ____

1. When did you last consult a doctor and why:____
2. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) ___________________________

____

Medical Information

In the past 10 years, have you had or have symptoms for or been treated for:

Diseases of the heart or circulatory system, including high blood pressure, heart attack, coronary disease, chest pain, heart murmur, rhythm abnormality, heart catheterization, echocardiogram, or treadmill test?	☐Yes ☐No
Cancer, tumors, lymphoma, leukemia, or any growths, lesions or polyps?	☐Yes ☐No
Diabetes, thyroid, glandular or endocrinal disorder?	☐Yes ☐No
Respiratory disorders ex. Asthma, chronic bronchitis, emphysema, shortness or breath or abnormal chest x-rays?	☐Yes ☐No
Disorder of stomach, liver, pancreas or intestinal tract including ulcers, colitis, Crohn's or cirrhosis?	☐Yes ☐No
Disorder of kidney's, prostate, bladder, reproductive organs, STD's, sugar or blood in urine?	☐Yes ☐No
Allergy or any disorder of the skin, eyes, ears, nose, throat, sinuses, larynx, spleen or lymph glands?	☐Yes ☐No
Stroke, Transient Ischemic Attack (TIA), Parkinson's, MS, Seizures, epilepsy, chronic headaches, memory changes or fainting?	☐Yes ☐No
Anxiety, depression, attempted suicide, ADD or psychosis, mental or nervous system disorder?	☐Yes ☐No
Anemia, hepatitis, AIDS, ARC , HIV or any other blood disorder?	☐Yes ☐No
Chronic back pain, arthritis, loss of limb, paralysis, gout?	☐Yes ☐No

Within the last 5 years, other than as noted above, have you:

Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised, to have any diagnostic test, surgery or treatment not yet completed?	☐Yes ☐No
Been a patient of a clinic or emergency room or had any diagnostic test that was not normal?	☐Yes ☐No
Used any drug, narcotic, or controlled substance not prescribed by a physician, or arrested, treated, counseled, or participated in a support group due to alcohol, controlled substance or drug use?	☐Yes ☐No

Family History

A family history of diabetes, cancer, heart disease, mental illness, or any other hereditary disorder							☐Yes ☐No
Family Member	Age if Living	Age at Death	Cause of Death	Family Member	Age if Living	Age at Death	Cause of Death
Father				Mother			
Brother(s)				Sister(s)			

PLEASE PROVIDE DETAILS OF ANY YES ANSWERS TO THE ABOVE QUESTIONS ON A SEPARATE PAGE INCLUDEING DATES OF DIAGNOSIS, TREATMENTS AND RESULTS.