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Health Screening Questionnaire

Agent Name:_____

Client Name:_____

☐ Male ☐ Female DOB: _____

Height: ____ft. ____in. Weight: _____lbs.

Ever used tobacco? ☐ No ☐ Yes

Last used: _____ Type: _____

Type of Plan:

☐Term Years: _____

☐Permanent ☐UL ☐Indexed UL ☐Whole Life

☐Permanent death benefit: ☐ (A) Level ☐ (B) Increasing

Face Amount: $_____ Single Premium: $_____

Annual Premium: $_____ Monthly Benefit: $_____

Have you previously been declined or rated for life insurance? □ Yes □ No

Reason for decline or rating:

_____

Are you receiving Worker's Compensation/Disability? □ Yes □ No

Are you Disabled? □ Yes □ No

Reason for the Disability:

_____

Actively working? □ Yes □ No If no, please explain?

_____

_____

Does the client have any family history (parent, sibling) of death before age 65 due to cardiovascular, cerebral vascular disease, diabetes, or cancer?

If yes, please explain:

_____

_____

Within the last 5 years has the client had a moving violation, reckless driving, or DUI/DWI?

If yes, please explain:

_____

_____

Any felony convictions or criminal history? If so, please explain:

_____

_____

Does the client participate in any dangerous activities/avocations (scuba diving, racing, skydiving, etc)?

If yes, please explain:

_____

_____

Is the client intending to travel to any foreign country?

If yes, please explain including length of stay:

_____

_____

U.S. Citizen? □ Yes □ No

Green Card? □ Yes □ No Applying for Citizenship? □ Yes □ No

1. Have you ever been diagnosed by a licensed physician as having any of the following conditions?

□ AIDS/HIV Positive	□ ALS (Lou Gehrig's Disease)	□ Alzheimer's Disease
□ Crest	□ Mental Retardation	□ Metastatic Cancer
□ Multiple Myeloma	□ Cystic Fibrosis	□ Multiple Strokes (TIA)
□ Muscular Distrophy	□ Multiple Sclerosis	□ Neurogenic Bladder
□ Scleroderma	□ Parkinson's Disease	□ Post Polio Paralytic
□ Dementia/Confusion	□ Spinal Cord Injury	□ Cerebral Atrophy
□ Kidney Failure	□ Liver Cirrhosis	□ Schizophrenia

2. If you checked any boxes in the previous question, please check all that apply. If not, skip this section:

☐ Amputation	☐ Anemia	☐ Autoimmune Disorder
☐ Angioplasty/Bypass Surgery	☐ Dizziness	☐ Back Disorder/Surgery
☐ Arthritis	☐ Epilepsy/Seizures	☐ Blindness/Degeneration
☐ Drug or Alcohol Abuse	☐ Falls	☐ Blood Disorder
☐ High Blood Pressure	☐ Heart Problems	☐ Bronchitis/Asthma
☐ Joint replacement/Fractures	☐ Aneurysm	☐ Hepatitis
☐ Fibromyalgia	☐ Cancer	☐ Mental/ Nervous Disorder
☐ Neurological Disorder	☐ COPD/Emphysema	☐ Peripheral Vascular Disease
☐ Urinary Incontinence	☐ Crohn's Disease	☐ Depression
☐ Respiratory Disorders	☐ Stroke/TIA	

☐ Diabetes Mellitus: Type ___*Insulin units per day____ Recent A1C Level____Blood Sugar Level___

☐ Elevated PSA or Prostate Disorders: *PSA levels _____

☐ Osteoporosis with fractures: *Bone density test t-scores _____

2 (b). If you checked any boxes in the previous 2 questions, provide details here. If not, skip this section:

Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

Reason: _____ Date: _____

Treatment or Therapy: _____

Residual Problems: _____

4. List all prescription medications taken over the past 12 months.

1. Medication: _____ Amount: _____Currently Taking? ☐
How Long Taking: _____ Reason Prescribed: _____

2. Medication: _____ Amount: _____Currently Taking? ☐
How Long Taking: _____ Reason Prescribed: _____

3. Medication: _____ Amount: _____Currently Taking? ☐
How Long Taking: _____ Reason Prescribed: _____

4. Medication: _____ Amount: _____Currently Taking? ☐
How Long Taking: _____ Reason Prescribed: _____

5. Medication: _____ Amount: _____Currently Taking? ☐
How Long Taking: _____ Reason Prescribed: _____