Pre-Underwriting Questionnaire

Please answer all questions applicable to the client's medical history.

Client Name ____ Date of Birth: _____/______/______

Male______ Female______ Amount of insurance requested________________________________

Any nicotine use within 60 months?_________________ If yes, type & date of last use:_____________________________________

Has client seen a doctor within past 3 years?________ If so, when & why?____

What tests were done?_____________________________ Results____

List any medications, including over-the-counter medications or vitamins. Indicate dosage.__________________________________

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Height:________________ Weight:___________________ Any weight change in past 12 months?_______________________

Latest blood pressure reading:_________________ EKG Results__________________ Cholesterol/HDL Results__________________

Family History: Has any family member had cancer, diabetes, high blood pressure, heart disease, or kidney disease prior to age 60? If yes, identify family member, disorder and age at onset.

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Cardiac Disorders : Any history of angina, heart attack, irregular heart-beat, valve disorder, coronary artery disease?

Please advise date of onset and treatment given:

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Hypertension

Date of diagnosis: _______________Your average readings: __________________Do you monitor readings at home? __________

Medications: ____Any other impairments? ____

Cancer

Type of cancer: _______________________________________Location:____

Staging: _____________Grade: __________________

Date of surgery: __________________Any radiation or chemo? __________________If yes, date treatment ended: ______________

Any recurrence of cancer: _____________________________Any other medical problems: _____________________________________

Substance Abuse

Date stopped using: ________________Kind of substance: _________________________ Attend AA or other programs:______________________ Type of treatment:____ Any relapses?____

Any motor vehicle violations or DUIs? _______________If so, describe & give details:____________________________________

Diabetes

Date diagnosed: ________________Treatment (oral meds, insulin, diet)?_________________# Units of insulin:______________

Any complications:____

Latest A1C reading: :_________________

Asthma/COPD

When diagnosed: _________________Medication:_________________________# of Attacks per year:____________________

Date & severity of last attack:____Seasonal?______________________________

Any hospitalizations?____When?_________________________________

Crohn's /Colitis

When diagnosed:_________________Any surgery?________________________If so, what?_____________________________

Current medication:____Date of last episode:_____________________

TIA/CVA Seizures *(transient ischemic attack / mini-stroke/stroke)*

Date of episode:________________# of episodes: _________________________Any residuals?___________________________

Type of treatment or medication:____

Psychiatric

Diagnosis:__________________Date:___________________Medication:___________________Hospitalization:______________

Suicide attempts? _________________________________Currently employed?____

Lab Abnormalities

What tests were abnormal? _______________________Results & date:____

Any diagnosis given? _____________________________How long has test been abnormal?______________________________

Aviation

Hours flown as Pilot or Co-Pilot:___________________Purpose (civilian, military):_______________________________________

Any Other Avocation

Please specify:____

Any impairment not listed above

Diagnosis given and date:____

Treatment:____

Medications:____

Date of last follow up: ___________________________________Test results:____

Additional comments *(Please attach additional page if needed)*

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