Lung Disease Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date of first Diagnosis		Has client improved since diagnosis	☐ Yes ☐ No
2	Type of Lung Disease	☐ Chronic Bronchitis	☐ Emphysema	☐ Asthma
		☐ Interstitial Lung Disease: Type_____		
3	Has client been hospitalized for treatment	☐ Yes ☐ No	*If yes, give details, dates and lengths of stay*	
4	Has a biopsy been done	☐ Yes	☐ No	
5	Have pulmonary function tests (breathing test ever been done	☐ Yes ☐ No	*If yes, provide results*	
6	Does client have any abnormalities on an ECG or X-Ray:	☐ Yes ☐ No	*If yes provide results*	
7	List current medications (accurate name, dosage and reason) including inhalers, steroids			
8	Does the client have any other health issues	☐ Yes ☐ No	*If yes provide details:*	