COPD Questionnaire

Chronic Obstructive Pulmonary Disease

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 Diagnosis			
2	What is the type of lung disease		Chronic Bronchitis	Asthma
			Emphysema	Restrictive Lung Disease
	Has the client ever been hospitalized for this condition?	☐ Yes ☐ No	If yes, please give details	
3	List current medications (accurate name, dosage and reason)			
4	Have pulmonary function test (breathing test ever been done	☐ Yes ☐ No	If yes, please give most recent test results :	
5	Does the client have any abnormalities on an EGG or X-ray?	☐ Yes ☐ No	If yes, please give details:	
6	List any other health issues (heart disease, etc.)			