Emphysema 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 Diagnosis		What is the cause	Asthma Occupation Smoking
2.	What is the degree of severity?		Does client use oxygen?	☐ Yes ☐ No
3	Has client ever been hospitalized	☐ Yes ☐ No	*If yes, give dates and lengths of stay*	
4	List current medications (accurate name, dosage and reason)			
5	Have pulmonary function tests been done?	☐ Yes ☐ No	*If yes, what were the results*	
6	Are there any restrictions of activities	☐ Yes ☐ No	*If yes provide details:*	
7	Does the client have any other health issues	☐ Yes ☐ No	*If yes provide details:*	