ASTHMA QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. What is the date of diagnosis? _____

2. How frequent are the attacks? _____

3. When did you last have an attack? _____

4. Have you ever been hospitalized? ___Yes ___No
(If yes, please give full details): _____
_____
_____

5. Are the attacks caused by any special circumstances or conditions? ___Yes ___No
(If yes please provide full details): _____
_____

7. What medicine have you taken to relieve the attacks? _____ _____

8. Have you ever been given cortisone or any other steroids? ___Yes ___No
(If yes, give full details of dosage): _____
_____
_____

9. Is the proposed insured taking medication for this condition or any other? ____Yes ____No
(If yes, please provide name, dosage, and frequency) _____
_____
_____
_____