Respiratory Disorders Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. What was the proposed insured's diagnosis?

   ___ Asthma ___ Bronchitis ___ Chronic Obstructive Pulmonary Disease (COPD)
   ___ Emphysema ___ Other: _____

2. Has pulmonary function testing been done? ___ Yes ___ No
   If yes, what type of test:
   ___ Forced Vital Capacity (FVC) Date of test: _____
   ___ Forced Expiratory Volume (FEV1) Date of test: _____
   ___ Other: _____

   Results of test: _____

3. Has a chest x-ray been done? ___ Yes ___ No
   If yes, provide date and results: _____
   _____

4. Are the attacks caused by any special circumstances or conditions? ___ Yes ___ No
   If yes, provide details: _____
   _____

5. Frequency of attacks/hospitalizations? _____

6. What medication(s) have you taken to relieve the attacks? _____
   _____

7. Have you ever been given cortisone or any other steroids? ___ Yes ___ No
   If yes, provide dates and dosage? _____
   _____

8. Does the proposed insured have any other medical conditions? ___ Yes ___ No
   If yes, provide details:_____
   _____

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