Chronic Obstructive Pulmonary Disease (COPD)

Name: ________________________ Date of Birth: ________________________

Height: _________ Weight: _______ Sex: M/F

Tobacco Usage: ________________ Face Amount: ______________________

State of Residence: _________________________

___Term 10 15 20 30 ___UL

1. What date was the proposed insured diagnosed with COPD? ______________________________

2. Has the proposed insured ever been hospitalized for this condition? ___Yes ___No
(If yes, please provide dates): ____
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3. Has a pulmonary function test ever been done? ___Yes ___No
(If yes, please provide the most recent date): ____
Results of the test: ____
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____

4. Does the proposed insured take any medication (including oxygen and inhalers)? ___Yes ___No
(If yes, please provide the name, dosage, and frequency): ___________________________________
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