



COPD Questionnaire

Agent: _____ **Phone:** _____ **Fax:** _____
Client: _____ **DOB :** _____ *Male* *Female*
Product/Face Amount: _____ **Height:** _____ **Weight:** _____

* **TOBACCO/NICOTINE USE (past or present):** **YES***** **NO**

***Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:

* Please provide the date of initial diagnosis and any relevant circumstances surrounding the diagnosis:

* Have you ever been hospitalized for respiratory complaints related to your diagnosis of COPD? If so, please provide date, duration and briefly outline circumstances and events leading up to any hospitalizations:

* Have pulmonary function tests been conducted? If so, provide the date of the most recent PFT performed, and results of the following test elements:

⇒ *FVC:*

⇒ *FEV1:*

* Have Chest X-rays, CT scans or any other imaging of the thoracic region been performed? If so, please indicate when the testing was performed and describe the results of the imaging studies, as outlined to you by your physician:

* **MEDICATIONS** - List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:

MEDICATION	DOSE	MEDICATION	DOSE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

* Do you currently require the use of supplemental oxygen at home, either continuously, or on an “as needed basis?”

YES NO

(if yes, please provide details as to any use of oxygen at home)

* **FAMILY HISTORY:** *(Family history may be a factor in determining rate class)* Is there a family history **(parent or siblings)** of the following conditions/disease onset prior to age 60:

Cardiac Disease YES NO Diabetes YES NO
 Stroke or TIA YES NO Cancer YES NO

Please provide details for any “YES” response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE <i>(if living)</i>	DECEASED <i>(list age @ time of death)</i>
<i>FATHER</i>				
<i>MOTHER</i>				
<i>SIBLING 1</i>				
<i>SIBLING 2</i>				

* Do you have any other significant health issues or medical conditions not outlined or mentioned on this form? *(Complete additional questionnaires, as indicated)*

Condition(s) - List treatment and current status:

NONE - NO other medical conditions or health issues.

* Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.

* Are there any other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?