



## Depression 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.:

\* Dates of initial and subsequent episodes of depression:

\* What specific type of depression has been diagnosed? Has the proposed insured been hospitalized for treatment of depression? If so, dates:

\* **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.	

\* Has the proposed insured been treated with electro shock therapy (ECT)? If so, date(s) of first and last treatments & total # of treatments.

\* Has the proposed insured had (or been diagnosed with) any of the following conditions?

- Alcohol Abuse*       *Drug Abuse*       *Personality Disorder*  
 *Psychotic Disorder*       *Suicidal thoughts*       *Suicide attempts*

\* Details if any to the above circled items:

\* **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 (if living)	DECEASED (list age @ time of death)
<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?**