



## Drug Use 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 indicate by placing a checkmark in the appropriate circle if you are using, or have used in the past, any of the substances listed below.

NOTE: Disclosures should encompass use of both "legal" and/or "illegal" substances TAKEN WITHOUT PRESCRIPTION, THOSE PRESCRIBED FOR AN EXTENDED PERIOD RESULTING IN PHYSICAL OR PSYCHOLOGICAL DEPENDENCE, THOSE USED "RECREATIONALLY" IN A MANNER CONTRADICTORY TO STANDARD MEDICAL APPLICATIONS OR ADVICE, OR THOSE OBTAINED WITHOUT A VALID AUTHORIZATION or PRESCRIPTION FROM A SOURCE OTHER THAN YOUR ESTABLISHED HEALTH CARE PROVIDER:

**OPIATES &  
DERIVATIVES:**

Heroin  Morphine  Demerol  Codeine  Methadone  
 Oxycodone  Vicodin/Hydrocodone  Other:

**BARBITURATES &  
SEDATIVE AGENTS:**

Amytal  Phenobarbital  Seconal  Nembutal  
 Diazepam (Valium)  Alprazolam (Xanax)  Other:

**CANNABIS:**

Marijuana  Hashish  Other:

**STIMULANTS:**

Methadrine/Methamphetamine  Benzadrine  Dexadrine  
 Cocaine  Any Prescription "Diet Pill(s)"  Other:

**HALLUCINOGENS/  
"DESIGNER" DRUGS:**

LSD  DMT  Mescaline  Peyote  Ecstasy  
 Psilocybin (Mushrooms)  Other:

\*If any of the above were used **IN THE PAST**, please provide a brief summary outlining the drug(s) used, estimated amount/quantity, frequency of use and the date(s) of use (both beginning and ending dates of use):

\*If any of the above are **PRESENTLY** being used, please provide a brief summary outlining the specific drug(s) used, estimated amount, frequency of use, date of last use and the date you began using the substance:

\*Is there any history of IV drug use?

NO

YES - please specify:

\*Do you presently consume alcoholic beverages?

YES - Briefly outline type, quantity and frequency of use:

NO - If "NO", date of alcohol cessation:

**\*Have you ever been advised by an MD or other medical profession to limit drug/substance use, consulted a doctor or received any form of treatment/therapy related to drug use, been deemed disabled or terminated from employment due to drug use OR been transported to and/or cared for in an Emergency Room due to drug use?**

- YES\*\*\*                       NO

\*\*\*If YES, please provide details, including dates, advice, therapy and/or treatment required:

**\* Are you currently, or ever been active in N.A., C.A., A.A., Rational Recovery Network or any other recovery/support groups?**

- YES\*\*\*                       NO

\*\*\*If YES, please provide brief summary of participation (please clarify if participation is ongoing):

**\*Have you been diagnosed with any liver disease/disorder?**

- YES\*\*\*                       NO

If YES, please specify diagnosis, treatment to date, current status and/or prognosis:

**\*Have you ever been arrested for driving under the influence of drugs or encountered any other legal consequences related to the use, transportation, importation or sale of any illicit drug or controlled substance?**

- NO
- YES – Please provide details (dates, charges, case disposition, current status, etc.)

**\*MEDICATIONS** – Please list ALL Current medications, specifically indicated for treatment or prevention of legitimate medical conditions or concerns (including prescription, non-prescription “over the counter” medications, including vitamins, herbal preparations, etc.) in the space provided below:

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

**\* 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.

\* **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>				

\* **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 you currently employed or capable of being employed?  YES  NO**

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