



## Inflammatory Bowel Disease 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 details as to the diagnosis and frequency of symptom recurrence:**

☞ *Date of initial diagnosis:*

☞ *Date of most recent episode:*

☞ *Total number of episodes or "flares" since diagnosis:*

☞ *Number of episodes or "flares" in past 6 months:*

☞ *Number of episodes or "flares" in past 2 years:*

☞ *Longest duration of symptoms (quantify in days, weeks, months):*

☞ *Average duration (quantify in days, weeks, months):*

\* **What specific condition(s) and/or symptoms have you been diagnosed with? (Check all that apply)**

- Irritable bowl syndrome*
- Colon spasms*
- Frequent diarrhea*
- Acute Proctitis*
- Chronic Proctitis*
- Ulcerative Colitis*
- Crohn's Disease*
- Other:*

\* **Has the proposed insured ever been hospitalized for the condition? If yes, please provide date(s):**

\* **Has surgery been preformed or recommended? If yes, when was the surgery completed/ planned?**

\* **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.	

\* What, if any, medications are taken specifically during flare-ups of symptoms, but not routinely taken:

\* **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?