



## Asthma 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.:

\* **When were you initially diagnosed with Asthma?**

\* **Have you been diagnosed with a specific form of asthma, or are asthma attacks precipitated by any specific factor?** (*allergies, exercise, climate/temperature, medication/chemical exposure, emotional stress, etc.*)

\* **Describe the frequency of asthma attacks and how often they have occurred:**

Time Frame	Frequency of Asthma Exacerbation(s)	Duration of Asthma Exacerbation(s)
<i>During past year</i>		
<i>During past 2 years</i>		
<i>During past 3 years</i>		
<i>During past 4 years</i>		

\* **Have you been hospitalized due to severe asthma attacks? If so, provide details:**

Date(s) of Hospitalization	Duration of Hospitalization(s)	Treatment(s) Required (including intubations, respirator, etc.):

\* **Does the client require home nebulizer therapy?** (*If so, please note how often, etc.*)

\* **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
<i>1.</i>		<i>5.</i>	
<i>2.</i>		<i>6.</i>	
<i>3.</i>		<i>7.</i>	
<i>4.</i>		<i>8.</i>	

\* **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?**