Pre-Underwriting Questionnaire

Please answer all questions applicable to the client's medical history.

Client Name ____ Date of Birth: _____/______/______

Male______ Female______ Amount of insurance requested_______________________________

Any nicotine use within 60 months?________________ If yes, type & date of last use:____________________________________

Has client seen a doctor within past 3 years?________ If so, when & why?____

What tests were done?____________________________ Results____

List any medications, including over-the-counter medications or vitamins. Indicate dosage._________________________________

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Height:________________ Weight:___________________ Any weight change in past 12 months?______________________

Latest blood pressure reading:_________________ EKG Results__________________ Cholesterol/HDL Results__________________

Family History: Has any family member had cancer, diabetes, high blood pressure, heart disease, or kidney disease prior to age 60? If yes, identify family member, disorder and age at onset.

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☐**Cardiac Disorders :** Any history of angina, heart attack, irregular heart-beat, valve disorder, coronary artery disease?

Please advise date of onset and treatment given:

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☐**Hypertension**

Date of diagnosis: _______________Your average readings: __________________Do you monitor readings at home? __________

Medications: ____Any other impairments? ____

☐**Cancer**

Type of cancer: ______________________________________Location:____

Staging: _____________Grade: __________________

Date of surgery: __________________Any radiation or chemo? _________________If yes, date treatment ended: ______________

Any recurrence of cancer: ____________________________Any other medical problems: ____________________________________

☐**Substance Abuse**

Date stopped using: ________________Kind of substance: ________________________ Attend AA or other programs:______________________ Type of treatment:____ Any relapses?____

Any motor vehicle violations or DUIs? ________________If so, describe & give details:_______________________________________

☐ **Diabetes**

Date diagnosed: _________________Treatment (oral meds, insulin, diet)?_________________# Units of insulin:_______________

Any complications:____

Latest A1C reading: :__________________

☐ **Asthma/COPD**

When diagnosed: __________________Medication:___________________________# of Attacks per year:______________________

Date & severity of last attack:____Seasonal?________________________________

Any hospitalizations?____When?___________________________________

☐ **Crohn's /Colitis**

When diagnosed:__________________Any surgery?_________________________If so, what?_______________________________

Current medication:____Date of last episode:_______________________

☐ **TIA/CVA Seizures** *(transient ischemic attack / mini-stroke/stroke)*

Date of episode:_________________# of episodes: ___________________________Any residuals?_____________________________

Type of treatment or medication:____

☐ **Psychiatric**

Diagnosis:___________________Date:____________________Medication:____________________Hospitalization:_______________

Suicide attempts? ___________________________________Currently employed?____

☐ **Lab Abnormalities**

What tests were abnormal? ________________________Results & date:____

Any diagnosis given? ______________________________How long has test been abnormal?________________________________

☐ **Aviation**

Hours flown as Pilot or Co-Pilot:____________________Purpose (civilian, military):____

☐ **Any Other Avocation**

Please specify:____

☐ **Any impairment not listed above**

Diagnosis given and date:____

Treatment:____

Medications:____

Date of last follow up: _____________________________________Test results:____

Additional comments *(Please attach additional page if needed)*

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