

RESPIRATORY QUESTIONNAIRE

Proposed Insured's Name:

DOB:

Sex: M F

Tobacco Use: Yes No Amount:

Height: Ft. In. Weight:

Broker's Name:

Face Amount:

BGA:

Phone:

Fax:

Proposed Insured please answer the following:

1. Have you ever been diagnosed with any of the following?

- | | | |
|--|-----------------------|----------------------|
| <input type="checkbox"/> Bronchitis | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Asthma | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Emphysema | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Chronic cough | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Pneumonia | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Sleep Apnea | Date of first attack: | Date of last attack: |
| <input type="checkbox"/> Other: | Date of first attack: | Date of last attack: |

2. How often do your attacks occur, and date of last attack?

3. How long do your attacks last?

4. Please give details of your attacks?

- Mild Moderate Severe Coughing of blood Coughing of phlegm

5. Have you ever lost any time from work due to any of these conditions?

- No Yes, How long, and why:

6. Have you ever experienced any of the following?

- Shortness of breath Wheezing
 Problems with climbing stairs or exercising Other respiratory/lung problems

Details:

7. Have you ever been hospitalized or had to go to the emergency room?

- No Yes, Most recent date:

Diagnosis:

8. Have you ever used tobacco products? No Yes, Most recent date:

Type: Amount: How long:

9. Are you or have you ever been on any medication(s) and/or treatment(s) No Yes

Name(s) and dosage:

10. Date you last consulted your physician:

11. Name and address of your physician(s):

12. ANY USE OF STEROIDS OR INHALERS? IF YES, DETAILS.

13. HAS case been shopped elsewhere, if so where & when?

Date: _____ Proposed Insured's Signature: _____