

# MEDICAL HISTORY QUESTIONNAIRE: COPD

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Tobacco Usage: \_\_\_\_\_ Coverage Information: \_\_\_\_\_

Never  
 Former Date Stopped: \_\_\_\_\_  
 Current Type: \_\_\_\_\_

Type:  Term  UL  IUL  
 WL  VUL  Survivorship

Face Amount: \_\_\_\_\_

Premium Tolerance: \_\_\_\_\_

## Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis \_\_\_\_\_

2. What is the type of lung disease?

Chronic bronchitis  Restrictive lung disease  
 Emphysema  Asthma

3. Has your client ever been hospitalized for this condition?

No  Yes; please provide details:

4. Has your client ever smoked?

Yes, and currently smokes (amount per day): \_\_\_\_\_  
 Yes, smoked in the past but quit (date quit): \_\_\_\_\_  
 Never smoked

5. Have pulmonary function tests (a breathing test) ever been done?

No  Yes; please provide details

6. Does your client have any abnormalities on an ECG or X-ray?

No  Yes; please provide details

7. Please list current medications

Name of Medication	Dosage	Reason

8. Are there any other health issues? (Additional Questionnaires may be required)  No  Yes

If yes, please provide details: