LUNG DISEASE

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnoses: _____

2. Type of lung disease:
☐ Interstitial lung disease; type _____
☐ Chronic bronchitis
☐ Emphysema
☐ Asthma

3. Was a biopsy done? ☐ No ☐ Yes

4. Has client improved since diagnosis? ☐ No ☐ Yes

5. Has client ever been hospitalized for this condition? ☐ No ☐ Yes; please give details

_____

_____

6. Has client ever smoked?
☐ Yes; currently smokes _____ (amount/day)
☐ Yes; smoked in the past but quit _____ (date)
☐ Never smoked

7. Have pulmonary function tests (breathing test) ever been done? ☐ No ☐ Yes; please give most recent test results

_____

_____

8. Does client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details

_____

_____

9. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

