



INSURED MEDICAL QUESTIONNAIRE
(Print or type clearly)

PERSONAL INFORMATION

1. Name of Insured: _____ Date of Birth: _____
2. Height: _____ Weight: _____ Sex: Male Female

LIFESTYLE AND HABITS

3. Has your weight changed in the last year? Yes No If yes, provide details: _____

4. Do you currently, or have you ever smoked cigarettes? Yes No If yes, for how many years? _____
If yes, how many daily? _____ Date of last use (if currently, write "current"): _____

5. Do you use any other form of tobacco? Yes No If yes, indicate type and frequency: _____

6. Do you drink beer, wine or spirits? Yes No If yes, indicate type and number of drinks per day: _____

7. Do you currently engage in sports or regular exercise? Yes No
If yes, provide details of type and frequency: _____

8. Do you live alone? Yes No If no, with whom? Spouse Significant other Other

9. Do you live in an assisted living facility or nursing home? Yes No

10. Are you in the process of entering assisted living facility or a nursing home? Yes No

11. Do you require assistance to perform any of the following activities? Yes No

If yes, check all that apply:

- Driving Walking Bathing Dressing Taking Medication Eating/Meal Planning
 Transferring (*Lifting and moving oneself from one place to another such as from a bed to a chair.*)

If yes, provide details: _____

MEDICAL HISTORY, CONDITIONS AND TREATMENTS

12. In the past five years, have you been diagnosed with or treated by a medical professional for any of the following conditions? (*Check all conditions that apply and provide details below*)

- Disease or disorder of the heart including atrial fibrillation, heart attack, coronary artery disease, etc.?
 Circulatory disorder including stroke, TIA (*mini-stroke*), aneurysm, arterial blockage, etc?
 Cancer, tumor or malignancy?
 Any immune system disorder?

