



RESPIRATORY QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
Address: _____ 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?

<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Coughing of blood	<input type="checkbox"/> Coughing of phlegm
-------------------------------	-----------------------------------	---------------------------------	--	---

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes, How long, and why: _____
-----------------------------	--

 6. Have you ever experienced any of the following?

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Problems with climbing stairs or exercising	<input type="checkbox"/> Other respiratory/lung problems

Details: _____

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

<input type="checkbox"/> No	<input type="checkbox"/> 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: _____
-