RESET

Life Inquiry
Medical History Questionnaire

Proposed Insured

_____ _____ _____ _____ _____
First Name MI Last Name Date of Birth

Check the condition to which the details in questions 2-12 relate:

1. ☐ Asthma ☐ Heart Disorder ☐ Nervous Disorder ☐ High Blood Pressure ☐ Sleep Apnea
   ☐ Diabetes ☐ Liver Disorder ☐ G. I. Tract Disorder ☐ Reproductive Disorder ☐ Other _____
   ☐ Tumor ☐ Back Disorder ☐ Urinary Disorder ☐ Respiratory Disorder
   Describe symptoms: _____ Date of onset:_____
   (If ulcer, any bleeding?)_____
   What special tests were done? _____ Results? _____
   What diagnosis was made?_____ Any malignancy? _____
   When?_____ Duration of illness? _____
2. What type treatment did you receive:

A. Surgery?	☐ Yes ☐ No	What type?
B. Radiation Therapy?	☐ Yes ☐ No	What type?
C. Medication?	☐ Yes ☐ No	What medication? Dosage?
D. Other?	☐ Yes ☐ No	Describe: If insulin, how many units? If diabetic, furnish date and results of last blood sugar test:

3. Are you currently under treatment? ☐ Yes ☐ No (If yes, give type and reason) _____
   (If no, when was treatment discontinued?) _____
4. Has additional treatment or surgery been suggested?_____
5. Have you been confined to the hospital? ☐ Yes ☐ No When?_____ How long? _____
6. When did you last consult a doctor? _____ Reason? _____
7. Have there been any recurrences? ☐ Yes ☐ No How many? _____
   Frequency? (Number of attacks in past 12 months) _____
8. Has this problem caused you to be disabled for more than one month? ☐ Yes ☐ No How long?_____
9. Amount of time missed from work/social activities in the past year related to this problem?_____
10. Any associated diseases or complications? ☐ Yes ☐ No Explain _____
11. Furnish blood pressure readings: Highest _____ / _____ When? _____
    Lowest _____ / _____ When? _____ Usual _____ / _____ Latest _____ / _____ When? _____
    Furnish names and addresses of all doctors and hospitals referenced above and indicate by "X" who has complete records.
    _____
    _____
12. Additional comments _____
    (Attach an additional sheet of paper if necessary.)

I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief.

Proposed Insured Signature

X

Signed at (city, state)_____

Signed on (date) _____

RESET

Additional Comments

Primary Proposed Insured

First Name _____ MI _____ Last Name _____ DOB_____

(Use the space below to provide explanations to any questions or details to any "yes" answers where the space provided on the previous page is insufficient or to provide any additional required information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

Primary Proposed Insured (PPI) Signature

X

PPI signed on (date) _____