

# 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 **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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

\_\_\_\_\_

\_\_\_\_\_

