Medical Questionnaire (Preliminary)

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In order decide where to place coverage and chart an application strategy, health history must be accounted for up-front. Carriers can be surprisingly sensitive, and each may have a different risk appetite for any given condition.

Do not complete this form without first completing the initial intake process, which is the basis for determining what you need. If you have not done this, call or use the intake form.

As you decide whether to check yes or no, err on the side of disclosure knowing this questionnaire is **off-the-record**. The official health statement that would be filed with any future application doesn't necessarily have to mirror your answers here.

This will not be shared. No carrier will see it.

Privacy Tip
This doesn't need to be returned. You could use this as a checklist of things to discuss over the phone.

Please be advised that insurers have the ability to conduct background checks related to your **prescription drug** history and use of **medical insurance** in the last five (5) years. It is important to disclose medical history voluntarily rather than waiting to see if they discover it because undisclosed history is in itself strongly adverse and predisposes underwriters against individual consideration.

When did you last see your Primary Care Doctor? _____

Reason ☐ Routine Physical ☐ Check-up ☐ Other

If "Other", what was the reason?

_____

What treatment or medication was given or recommended?

_____

Was your Primary Care Doctor the last physician seen? ☐ Yes ☐ No If "No" provide the following details

When did you last see the non-primary doctor? _____

What was the reason?

_____

What treatment or medication was given or recommended?

_____

SECTION C: Proposed Insured's Health/Medical History

If you answer "Yes" to any of the questions below, please provide details in the Additional Details section.

1. Height _____ ft _____ in **2.** Weight _____ lbs

3. Have you lost more than 10 lbs in the past year? ☐ Yes ☐ No *If "Yes," please provide the following information:*

a. Reason for change in weight: ☐ Diet ☐ Exercise ☐ Illness ☐ Pregnancy (women only)

☐ Other _____

b. How much weight have you lost in the past year? _____ lbs

4. In the past 10 years, have you been diagnosed with, treated for, tested positive for, been given medical advice by a member of the medical profession or received a consultation or counseling for:

a. any cancer or tumor? ☐ Yes ☐ No

b. high blood pressure, heart murmur, irregular heartbeat, palpitations, heart attack, coronary artery disease, chest pain, or any other disease or disorder of the heart, blood vessels or circulatory system? ☐ Yes ☐ No

c. high blood sugar, high cholesterol, diabetes, thyroid disorder or any disease or disorder of the blood (except HIV), skin, glands or endocrine system? ☐ Yes ☐ No

d. disease or disorder of the kidney, bladder or urinary systems (including blood or protein in the urine)? ☐ Yes ☐ No

e. any disease or disorder of the prostate, breasts, reproductive system (including infertility) or complications of pregnancy? ☐ Yes ☐ No

f. Crohn's disease or colitis, blood in stool, hepatitis or any disease or disorder of the liver, colon, pancreas, spleen, stomach, intestines, esophagus, rectum, gall bladder or hernia or surgery for weight loss? ☐ Yes ☐ No

g. arthritis, chronic pain, auto-immune or connective tissue disorder, multiple sclerosis, Parkinson's disease or tremor? ☐ Yes ☐ No

h. any disease, disorder or condition of the back, neck, spine/spinal cord, joints, limbs or bones? ☐ Yes ☐ No

i. asthma, emphysema, chronic obstructive pulmonary disease, shortness of breath, disease or disorder of the lungs or respiratory system, allergies or any sleep disorder including sleep apnea? ☐ Yes ☐ No

j. seizure disorder, stroke, transient ischemic attack (TIA), memory loss, Alzheimer's disease, dizziness, headache or disease or disorder of the brain? ☐ Yes ☐ No

k. any disease or disorder of the eyes, vision, ears, hearing, nose or throat? ☐ Yes ☐ No

l. anxiety, depression, stress, attention deficit disorder (ADD), post-traumatic stress disorder (PTSD) or any other mental, nervous, eating or emotional disorder? ☐ Yes ☐ No

m. chronic fatigue syndrome, fibromyalgia, neuritis, neuralgia, narcolepsy, insomnia, restless leg syndrome, Epstein Barr virus, Lyme Disease, muscle weakness or any disease or disorder of the muscles, nerves or nervous system? ☐ Yes ☐ No

5. Have you had an amputation of any kind or any physical deformity, handicap or impairment that has been diagnosed by a member of the medical profession? ☐ Yes ☐ No

6. Within the past 10 years, have you received any speech, physical or occupational therapy? ☐ Yes ☐ No

7. Within the past 10 years, have you tested positive, been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

8. Are you currently taking prescription medication or have been prescribed any medication within the past 6 months that was not already disclosed? ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

9. Are you currently taking non-prescription medication or supplements? ☐ Yes ☐ No

10. Describe your complete use of tobacco or tobacco products below. This includes, but is not limited to: cigarettes, cigars, pipes, chewing tobacco, snuff, hookah, nicotine gum, nicotine patch and electronic delivery devices. *If additional space is needed, please provide in the Additional Details section.*

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Cigarettes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Cigars		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Pipes		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Chewing Tobacco		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other _____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used tobacco products.			

11. Describe your complete use of alcohol below. This includes, but is not limited to: beer, wine and liquor. *If additional space is needed, please provide in the Additional Details section.*

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

Type of Product	Quantity	Frequency	Date Last Used (mm/dd/yyyy)
Beer		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Wine		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Liquor		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
Other_____		☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly	
☐ I have never used alcohol.			

12. Describe your use of marijuana, in any form, in the last 5 years below. If you have not used marijuana in the last 5 years, check here ☐

a. Purpose: ☐ Recreational/Social ☐ Medicinal *If purpose is medicinal, please provide the below information:*

i. Reason for Use: _____

ii. Prescribing Doctor's Name: NR

b. Date Last Used (mm/dd/yyyy): _____

c. Frequency: _____ times per: ☐ day ☐ week ☐ month ☐ year

13. **Age 15 and over:** In the past 10 years, have you used stimulants, cocaine, heroin, morphine, hallucinogens, methamphetamines, narcotics, opioids or any other illicit drug or controlled substance except as prescribed by a member of the medical profession? *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

14. **Age 15 and over:** In the past 10 years, have you had or been advised to have counseling or treatment for alcohol or drug use or been advised by a member of the medical profession to limit your use of alcohol or drugs? This includes both prescription and non-prescription drugs. *If "Yes," complete the Alcohol and Drug Usage Supplement.* ☐ Yes ☐ No

15. **Age 15 and over:** Are you now pregnant? *If "Yes," expected delivery date*: _____ ☐ Yes ☐ No

SECTION C: Proposed Insured's Health/Medical History (continued)

16. Are you currently receiving or within the last 5 years, have you had a sickness, injury or any other condition for which you received or applied for any disability benefits including worker's compensation, social security disability insurance or any other form of disability insurance? ☐ Yes ☐ No

17. Within the past 5 years, have you had a physical exam, check-up of any kind or diagnostic tests performed that were not previously disclosed, except for HIV or AIDS tests? ☐ Yes ☐ No

18. Within the past 5 years, have you been advised by a member of the medical profession to have surgery or any diagnostic tests that were *not* performed, except for HIV or AIDS tests? ☐ Yes ☐ No

19. Do you have an appointment scheduled within the next 6 months to seek medical attention, excluding routine physicals? ☐ Yes ☐ No

20. Other than as previously stated on this application, are you currently or in the past 5 years have you received medical advice, counseling, or treatment for any medical, surgical, psychological, or psychiatric condition from a medical professional or have you been a patient in a hospital, clinic, rehabilitation center or other medical facility? ☐ Yes ☐ No

21. Age 6 and below and Life coverage only:

a. Was the Proposed Insured born prematurely (gestational age less than 37 weeks)? ☐ Yes ☐ No
If "Yes," provide gestational age: _____

b. Was the Proposed Insured's birth weight less than 5 pounds? ☐ Yes ☐ No

c. Has the Proposed Insured ever been evaluated, tested, treated for or diagnosed with any growth or developmental delays or failure to thrive? ☐ Yes ☐ No

SECTION D: Family History

1. To the best of your knowledge, have any immediate family members (father, mother or sibling) died before age 60 from cardiovascular disease or cancer? ☐ Yes ☐ No

2. To the best of your knowledge, have any immediate family members (father, mother or sibling) been diagnosed by a member of the medical profession before age 60 with cardiovascular disease or cancer? ☐ Yes ☐ No

3. Have any immediate family members been diagnosed or treated by a member of the medical profession for diabetes, mental illness or a hereditary condition of the brain, muscles, nervous system, eyes or kidneys? ☐ Yes ☐ No

4. Complete the chart below for all immediate family members (father, mother or sibling). The Gender column only needs to be completed for siblings. *If additional space is needed, please provide in the Additional Details section.*

Family Member	Gender Male (M) or Female (F)	Age of Onset	Age if Living	Age at Death	Condition and/or Cause of Death (if applicable)
Father	NA				
Mother	NA				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				
Sibling	☐ M ☐ F				

SECTION E: Additional Details

Provide all details to any "Yes" answers, identifying each detail by question number. Include, if applicable, all dates, diagnoses, stage or severity of diagnoses, known symptoms, tests performed, treatment (recommended or received), medications (types and amounts), surgeries, length of disability, days of work missed, job restrictions or modifications due to injury or sickness, physical limitations and the names and addresses of all treatment providers including, but not limited to, physicians, medical or mental health professionals, counselors, psychotherapists, chiropractors, acupuncturists, practitioners or hospitals, clinics or other medical or mental health facilities. For additional space use the Supplement to the Application for Insurance.