Asthma/Lung Disease Questionnaire

Name _____ Sex M F Date of Birth _____

Height _____ Weight _____ Smoker? Y N State _____

Coverage Desired: Amount _____ Plan Desired? _____

Have you ever been Rated or Declined for insurance? If YES Complete details please

_____

Have you ever been told you have: (CIRCLE ALL)

ASTHMA EMPHYSEMA COPD CHRONIC BRONCHITIS RESTRICTIVE LUNG DISEASE

Have you been hospitalized for any of these? YES NO

If so, when?_____

Did you ever smoke? YES NO

If yes, when did you quit?_____

When was your last Pulmonary Function Test? _____

Results?_____

Do you currently use an inhaler? YES NO If so, how often?_____

Any Abnormal EKG or X-Ray findings? YES NO

_____

What Lifestyle Changes have you made to treat your illness? _____

Please list all medications being taken:

_____

_____

Do you have any other major health problems? (example: cancer, etc)?

_____

_____

_____

Broker Submitting Questionnaire:

_____

Address _____

Phone: _____ FAX: _____ E-mail: _____

Please send completed form to: Victorson Associates, Inc. 321 E. Main St., Smithtown, NY 11787

You may Fax to: (631) 265-7054 or E-mail to: vainc@victorson.com