## **Underwriting Questionnaire**

## **Asthma**



Producer Name	Phone		Date	_ \
Client Name	Date of Birt	:h		
☐ Male ☐ Female Face Amount		Max Premiun	\$/yr.	
☐ Term ☐ Permanent Has the clien	t ever used any form o	of tobacco (cigarettes	, cigars, pipe, snuff, etc.)	? □Yes □No
Frequency	Date of last use		Type	
Date of diagnosis	Type of asthma diagr	nosed		
What leads to asthmatic attacks				
When did attacks occur			Number of attacks per year (state if continuous)	
During past year				
During past 2 years				
If the client has been hospitalized or had ER v	isits due to severe asth	ıma attacks, complet	e the information below	
Date(s) of hospitalization/ER visit(s) Length of hos		,	Special circumstances	
What medications are being used to control a	asthmatic attacks			
Name of medication (prescription or otherwise)		Dates used	Quantity taken	Frequency taken

List any other major health problems the client has:

List any abnormal EKG, chest x-ray, or pulmonary function testing:



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