CONMARK INCORPORATED

| Date: |
|---|
| PRELIMINARY INQUIRY<br>Not an application for life insurance |

# HEALTH HISTORY QUESTIONNAIRE

**CLIENT INFORMATION** — **All questions contained in this questionnaire are strictly confidential.**

| **Proposed Insured Name;** ☐ M ☐ F | **DOB:** |
|---|---|
| **Height_____ Weight_____** | **Tobacco/Nicotine Usage**:<br>1. Have you ever smoke cigarettes: Y / N if yes, date of last use.<br>2. Have you used other tobacco or nicotine containing product: Y / N<br>If yes, provide type and last date of use: |

## AGENT INFORMATION

Name:_____ Telephone:_____ Fax:_____

e-mail:_____ Address:_____

## MEDICAL HISTORY – PRIMARY CARE PHYSICIAN

Doctor's Name: Address:
Date Seen and Reason:

## MEDICAL HISTORY – OTHER DOCTORS CONSULTED IN THE PAST 5 YEARS

| Date | Reason | Doctor Address |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| | | |

## HOSPITALIZATONS: (Hospital, Clinic or other Health Facility where you have been treated)

| Date | Reason | Hospital/Clinic/Health Facility |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

| HOSPITALIZATONS: (Hospital, Clinic or other Health Facility where you have been treated) | | |
|---|---|---|
| **Date** | **Reason** | **Hospital/Clinic/Health Facility** |
| 4. | | |
| 5. | | |
| 6. | | |

| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| DRUG AND ALCOHOL USAGE | | | |
|---|---|---|---|
| **Alcohol** | Do you drink alcohol? | ☐ Yes | ☐ No |
| | If yes, what kind? | | |
| | How many drinks per week? | | |

Have you ever consulted a doctor or received treatment because of alcohol use? Y / N
Have you ever been arrested for driving under the influence of alcohol? Y / N
If yes, provide date(s):

## ADDITIONAL MEDICAL HISTORY

**Coronary** ☐ check here if this area is not applicable

1. Date of diagnosis of first chest pain:
2. Number of diseased vessels:
3. Dates/details of treatment/surgery:

4. Date of last stress EKG:
   Results:
   Doctor of facility:
5. Any pain since treatment or surgery?:

**Cancer** ☐ check here if this area is not applicable

1. Exact name and location of cancer:
2. Stage and grade:
3. Dr or facility who has pathology report:

4. Dates/details of treatment/surgery:

**Diabetes** ☐ check here if this area is not applicable

1. Date of diagnosis:
2. Treatment: (circle one) Diet Only Oral Medication Insulin
3. Do you regularly test your blood glucose? Y / N
   Results: Frequency:

4. Latest result of glycohemoglobin (A1C) test: _____% Date:
5. Have you been diagnosed with having protein and/or microalbumin in your urine? Y / N

**Diabetis (Continued)**

6. Any eye trouble? Y / N
7. Heart trouble? Y / N
8. High blood pressure? Y / N
9. Kidney trouble? Y / N
10. Neuritis/Neuralgia? Y / N
11. Insulin reactions? Y / N

| **Hazardous Activities** | ☐ check here if this area is not applicable |
|---|---|

1. Are you a private pilot? Y / N If yes, provide details below:
   Do you have an IFR (instrument flight rating)? Y / N
   How many hours do you fly per year?:
   How many total solo hours:

3. Do you participate in any of the following activities (please circle all that apply)
   Sky Diving Scuba Diving Racing (auto/mortocycle) Mountain Climbing Other_____

## FAMILY HEALTH HISTORY

Have any parents or siblings been diagnosed or died from heart disease or cancer: Y / N
If yes, please provide the following details:

| | AGE | DIAGNOSIS | AGE OF DISEASE ONSET | AGE AT DEATH |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Sibling** | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |
| | ☐ M ☐ F | | | |