



Health Questionnaire

Proposed Insured

Name: _____
Birthdate: _____
Sex: ____ Height: ____ Weight: ____
County: _____ Zip: _____
Tobacco use in the past 5 years?
(Amount and type) _____

Spouse

Name: _____
Birthdate: _____
Sex: ____ Height: ____ Weight: ____
County: _____ Zip: _____
Tobacco use in the last 5 years?
(Amount and type) _____

Children to be covered:

Date of Birth	Sex
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical/Health History: (Please indicate all conditions you are currently being treated for as well as all past medical conditions. This includes diagnosis, date of service and all **medications**.)

**** PLEASE FILL OUT ALL INFORMATION REQUESTED AS ACCURATELY AS POSSIBLE. IF IN DOUBT, WRITE IT DOWN****

Thank you for taking the time to complete this information. If you have any questions, please give me a call. Completed forms may be faxed to me at 614-340-7955.