

ASTHMA 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 that you had: (Circle those that apply)

CHRONIC BRONCHITIS EMPHYSEMA ASTHMA RESTRICTIVE LUNG DISEASE

Were you hospitalized for this? Y N If Yes, for how long? _____

Did you EVER Smoke? Y N If Yes, when quit _____

Do you use an Inhaler? Y N If, Yes, Medication and Dosage _____

Had a Pulmonary Function Test? Y N If Yes, Date and Test Results _____

What medications are currently being taken? _____

Do you have any abnormalities on an EKG or X-Ray? If Yes Complete Details _____

Any other medical problems or anything else that the underwriter should know? Y N Complete details please

Additional Comments _____

Broker Submitting Questionnaire: _____

Address: _____

Phone: _____ FAX: _____ E-mail: _____

Please send completed form to: Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787
You may Fax to: (631) 265-7456 or E-mail to: vainc@victorson.com