

# Preliminary Health Questionnaire

Please fax completed forms:  
(951) 372-8288  
Phone: (951) 372-8266

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. Weight: \_\_\_\_\_ Lbs.

Amount of Insurance: \_\_\_\_\_ Plan (circle one): Term Universal Life Whole Life

Tobacco User: Yes No If yes, circle type(s) of usage: Cigarettes Cigars Pipe Chew  
Frequency of use: \_\_\_\_\_

Has any immediate relative (father, mother, sister, brother) has an occurrence of, or died from, heart disease, diabetes complications, or cancer prior to the age of 60? If yes, please specify.

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Ever been treated for elevated blood pressure? Yes No List date of diagnosis: \_\_\_\_\_

How long has BP been controlled? \_\_\_\_\_

Most recent BP readings: \_\_\_\_\_

Medications taken for BP: \_\_\_\_\_

Ever been treated for elevated cholesterol? Yes No List date of diagnosis: \_\_\_\_\_

How long has cholesterol been controlled? \_\_\_\_\_

Most recent cholesterol readings: \_\_\_\_\_

Medications taken for cholesterol: \_\_\_\_\_

Angioplasties, bypass, etc.? (dates, reason, number) \_\_\_\_\_

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Any cancer or surgery in the past 20 years? (dates, currently under treatment or resolved) \_\_\_\_\_

Any history of diabetes? (type, duration, A1C reading) \_\_\_\_\_

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Name all medications currently taken (if not listed above), including dosage and frequency.

Any history of drug or alcohol abuse? \_\_\_\_\_

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More than 2 moving violations in 3 years, DUI, or suspension in past 5 years? \_\_\_\_\_

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Resident Status: (circle one)    U.S. Citizen    Permanent Resident    Green Card Holder  
Other Visa (Specify): \_\_\_\_\_

Do you fly an airplane or participate in any other hazardous activities (scuba diving, sky diving, etc.)?  
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Any other medical impairment(s)? \_\_\_\_\_

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**Physicians/Hospitals visited in the last 5 years:**

Physician/Hospital Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Date & Reason for Visit \_\_\_\_\_

Physician/Hospital Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Date & Reason for Visit \_\_\_\_\_

**Life Agent Information:**

Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Email: \_\_\_\_\_

**For any questions or for supplemental medical questionnaires, please contact me at:**

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