CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. What is the type of lung disease?

☐ Chronic bronchitis ☐ Emphysema ☐ Restrictive lung disease ☐ Asthma

2. Date first diagnosed: _____

3. Has your client ever been hospitalized for this condition? ☐ No ☐ Yes; please give details _____

_____

4. Has your client ever smoked?

☐ Yes, and currently smokes _____ (amount per day)

☐ Yes, smoked in the past but quit _____ (date quit)

☐ Never smoked

5. Is client on any medications now? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

6. Have pulmonary function tests (a breathing test) ever been done? ☐ No ☐ Yes; please give details _____

_____

_____

7. Client's build: Height: _____' _____" Weight: _____

8. Does your client have any abnormalities on an ECG or X-ray? ☐ No ☐ Yes; please give details _____

_____

9. Does client have any other major health issues (heart disease, etc.)? (additional questionnaires may be required)

☐ No ☐ Yes; please give details _____

_____

10. Does your client require supplemental oxygen? ___ Yes ___ No

