INSURANCE DESIGNERS

Asthma Questionnaire

Insurance Designers of Central Texas, LLC

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Phone 512-257-9700 FAX 512-257-9701

Today's Date: **Agent:**

Full Name: **Male or Female?**

Height and weight: **Date of Birth:**

Note: If you are able to fax us at least your three most recent pulmonary function tests, it will help us obtain the most accurate tentative quote.

1. **Month and year diagnosed:_____ Age at diagnosis:_____**

2. **Was is it diagnosed as ___ Mild ___ Moderate ___ Severe**
   (Please call your doctor and ask for the specific diagnosis if you are not sure).

3. **Have you ever had an asthma attack? ___ Yes ___ No**
   If yes, how many and when?

   Were you hospitalized or taken to the emergency room? ___ Yes ___ No

4. **What medications do you take, reason, dosage and how often?**

5. **How often do you see your doctor?**
   _____Every six months _____Every 12 months _____Other (explain):

6. **Have you ever had any pulmonary function tests? ___ Yes ___ No**
   If Yes, list dates:

7. **Has your weight remained stable in the past year? ___Yes ___ No**
   If no: Lost _____ pounds OR Gained _____ pounds

8. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
____Smokeless	____daily/monthly/yearly	_____	__Yes __ No
____Cigarettes	____per day/month/year	_____	__Yes __ No
____Cigar	____per day/month/year	_____	__Yes __ No
____Patch/Gum	____per day/month/year	_____	__Yes __ No