



# General Health Questionnaire and Quote Request

Send to either  
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Today's Date: Agent: Male or Female?  
Full Name: Date of Birth: Height and weight:  
Face amount: Term or permanent? Term length:

Do you have any history of (check all that apply):

- Elevated cholesterol
- Heart arrhythmias (no heart disease)
- Cancer (including skin cancer)
- Alcohol and/or Drug abuse
- Elevated liver enzymes
- Sleep apnea
- Anxiety/depression
- Chronic migraines
- Elevated blood pressure
- Heart disease (CAD)
- Elevated blood sugar (Diabetes)
- Respiratory/Lung disorder
- Stroke / TIA
- Hepatitis
- Digestive/Gastrointestinal disorder
- Chronic pain

For boxes checked above, list date diagnosed and types of treatment, including medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship	Current age if living	Age deceased	List age diagnosed with any heart disease, cancer, diabetes, stroke
Father			
Mother			
Sibling			
Sibling			

Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
<input type="checkbox"/> Smokeless	<input type="checkbox"/> daily/monthly/yearly	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigarettes	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cigar	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Patch/Gum	<input type="checkbox"/> per day/month/year	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you participate in any of the following (check all that apply):

- Scuba/Sky diving
- Mountain/Rock climbing
- Aviation (Pilot)
- Active military duty
- Felony
- Foreign travel outside the U.S. or Canada
- Missionary work

How many moving/traffic violations (i.e. speeding tickets, license suspension) have you had in the past 3 years? \_\_\_\_\_ Have you ever had a DUI?  No  Yes, year(s): \_\_\_\_\_