



**GENERAL HEALTH QUESTIONNAIRE  
AND QUOTE REQUEST FORM**

Client's Name: \_\_\_\_\_ M F  
 DOB / Age: \_\_\_\_\_ Height and Weight: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Term or Permanent? \_\_\_\_\_ Type: \_\_\_\_\_

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

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

For boxes checked above, list date diagnosed and types of treatment, include medications:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Relationship	Current age, if living	List age diagnosed with any heart disease, cancer, diabetes, or stroke, and diagnosis	Age at death	Cause of death
Father				
Mother				
Sibling				
Sibling				

Please indicate if EVER used:

Type:	Amount per (circle frequency):			Date last used:	Still use?	
Smokeless	Daily	Monthly	Yearly	_____	Yes	No
Cigarettes	Day	Month	Year	_____	Yes	No
Cigar	Day	Month	Year	_____	Yes	No
Patch / Gum	Day	Month	Year	_____	Yes	No
Marijuana	Day	Month	Year	_____	Yes	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): \_\_\_\_\_

Financial Advisor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_