



# Appletree Financial Network BUILD AND BLOOD PRESSURE QUESTIONNAIRE

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Proposed Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Tobacco Use:  Yes  No Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. In. Weight: \_\_\_\_\_  
Broker's Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
BGA: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Proposed Insured please answer the following:

1. What was your weight 12 months ago?
2. If you have elevated blood pressure when did you first notice it?
3. Please provide your current blood pressure reading:
4. What have your blood pressure readings been over the last 24 months:

Date:	Reading:	Date:	Reading:
Date:	Reading:	Date:	Reading:
Date:	Reading:	Date:	Reading:

5. Do you know your Cholesterol level?  No  Yes, level: \_\_\_\_\_  
HDL/Cholesterol ratio: \_\_\_\_\_

6. Have you been diagnosed with or had any of the following symptoms:

<input type="checkbox"/> Chest pain/angina	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Proteinuria	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Pulse Disorder	<input type="checkbox"/> Abnormal EKG		

Details:

7. Have you had an EKG done within the last 5 years?  No  Yes, Date: \_\_\_\_\_  
Results: \_\_\_\_\_

8. Do you exercise regularly?  No  Yes  
Details: \_\_\_\_\_

9. Are you on any medication(s)?  No  Yes, Name(s) and dosage(s): \_\_\_\_\_

10. Date you last consulted your physician: \_\_\_\_\_

11. Name and address of your physician(s): \_\_\_\_\_

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Underwriter's Notes:

Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_