



# Appletree Financial Network RESPIRATORY QUESTIONNAIRE

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: \_\_\_\_\_

Proposed Insured please answer the following:

1. Have you ever been diagnosed with any of the following?

- |  |                             |                            |
|--|-----------------------------|----------------------------|
| <input type="checkbox"/> Bronchitis    | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Asthma        | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Emphysema     | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Chronic cough | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Pneumonia     | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Sleep Apnea   | Date of first attack: _____ | Date of last attack: _____ |
| <input type="checkbox"/> Other:        | Date of first attack: _____ | Date of last attack: _____ |

2. How often do your attacks occur, and date of last attack?

3. How long do your attacks last?

4. Please give details of your attacks?

- Mild     Moderate     Severe     Coughing of blood     Coughing of phlegm

5. Have you ever lost any time from work due to any of these conditions?

- No     Yes, How long, and why: \_\_\_\_\_

6. Have you ever experienced any of the following?

- Shortness of breath     Wheezing  
 Problems with climbing stairs or exercising     Other respiratory/lung problems

Details: \_\_\_\_\_

7. Have you ever been hospitalized or had to go to the emergency room?

- No     Yes, Most recent date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

8. Have you ever used tobacco products?  No     Yes, Most recent date: \_\_\_\_\_

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ How long: \_\_\_\_\_

9. Are you or have you ever been on any medication(s) and/or treatment(s)?  No     Yes

Name(s) and dosage: \_\_\_\_\_

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

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

Underwriter's Notes: \_\_\_\_\_

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