The Bollinger Group
FINANCIAL SERVICES INTERMEDIARIES

Date:

PRELIMINARY INQUIRY

Not an application for life insurance

HEALTH HISTORY QUESTIONNAIRE

CLIENT INFORMATION

All questions contained in this questionnaire are strictly confidential.

Proposed Insured Name; ☐ M ☐ F	**DOB:**
Height_____ **Weight**_____	**Tobacco/Nicotine Usage:** 1. Have you ever smoke cigarettes: Y / N if yes, date of last use. 2. Have you used other tobacco or nicotine containing product: Y / N If yes, provide type and last date of use:

AGENT INFORMATION

Name:_____ Telephone:_____ Fax:_____

e-mail:_____ Address:_____

MEDICAL HISTORY – PRIMARY CARE PHYSICIAN

Doctor's Name: Address:

Date Seen and Reason:

MEDICAL HISTORY – OTHER DOCTORS CONSULTED IN THE PAST 5 YEARS

Date	Reason	Doctor Address
1.		
2.		
3.		
4.		

HOSPITALIZATONS: (Hospital, Clinic or other Health Facility where you have been treated)

Date	Reason	Hospital/Clinic/Health Facility
1.		
2.		
3.		

HOSPITALIZATONS: (Hospital, Clinic or other Health Facility where you have been treated)		
Date	**Reason**	**Hospital/Clinic/Health Facility**
4.		
5.		
6.		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

DRUG AND ALCOHOL USAGE			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		

Have you ever consulted a doctor or received treatment because of alcohol use? **Y / N**
Have you ever been arrested for driving under the influence of alcohol? **Y / N**
If yes, provide date(s):

ADDITIONAL MEDICAL HISTORY

Coronary ☐ check here if this area is not applicable

1. Date of diagnosis of first chest pain:
2. Number of diseased vessels:
3. Dates/details of treatment/surgery:

4. Date of last stress EKG:
   Results:
   Doctor of facility:
5. Any pain since treatment or surgery?:

Cancer ☐ check here if this area is not applicable

1. Exact name and location of cancer:
2. Stage and grade:
3. Dr or facility who has pathology report:

4. Dates/details of treatment/surgery:

Diabetes ☐ check here if this area is not applicable

1. Date of diagnosis:
2. Treatment: (circle one) Diet Only Oral Medication Insulin
3. Do you regularly test your blood glucose? Y / N
   Results: Frequency:

4. Latest result of glycohemoglobin (A1C) test: _____% Date:
5. Have you been diagnosed with having protein and/or microalbumin in your urine? Y / N

Diabetis (Continued)

6. Any eye trouble? Y / N
7. Heart trouble? Y / N
8. High blood pressure? Y / N
9. Kidney trouble? Y / N
10. Neuritis/Neuralgia? Y / N
11. Insulin reactions? Y / N

Hazardous Activities

☐ check here if this area is not applicable

1. Are you a private pilot? Y / N If yes, provide details below:
   Do you have an IFR (instrument flight rating)? Y / N
   How many hours do you fly per year?:
   How many total solo hours:

3. Do you participate in any of the following activities (please circle all that apply)
   Sky Diving Scuba Diving Racing (auto/mortocycle) Mountain Climbing Other_____

FAMILY HEALTH HISTORY

Have any parents or siblings been diagnosed or died from heart disease or cancer: Y / N
If yes, please provide the following details:

	AGE	DIAGNOSIS	AGE OF DISEASE ONSET	AGE AT DEATH
Father				
Mother				
Sibling	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			