

MEDICAL HISTORY QUESTIONNAIRE: CROHN'S DISEASE

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

Coverage Information:

Never

Type: Term

UL

IUL

Former Date Stopped: _____

WL

VUL

Survivorship

Current Type: _____

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis _____

2. How often does your client visit his/her physician? _____

3. Date of last visit: _____

4. Please check if your client has (had) any of the following:

Hospitalizations for this disorder (list dates): _____

Surgery for this disorder (list dates): _____

Colonoscopy (date of most recent): _____

5. Please list current medications

Name of Medication	Dosage	Reason

6. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____
