MEDICAL HISTORY QUESTIONNAIRE: CROHN'S DISEASE

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never

☐ Former Date Stopped: _____

☐ Current Type: _____

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL

☐ WL ☐ VUL ☐ Survivorship

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: