

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE QUESTIONNAIRE**

Agent: _____	Phone: _____	Fax: _____
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Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____
Face Amount: _____ Max. Premium: \$_____/year	<input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N	If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N	
If Yes, please provide details: _____	
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____	

**(1) Date of diagnosis:** \_\_\_\_\_

**(2) Type of lung disease diagnosed with Chronic Obstructive Pulmonary Disease (COPD):**  
 Asthma  Chronic Bronchitis  Emphysema  Restrictive Lung disease  Other: \_\_\_\_\_

**(3) Has the proposed insured ever been hospitalized for the condition?**  No  Yes Date(s): \_\_\_\_\_

**(4) Is the proposed insured taking medications (incl. inhalers and oxygen)?**  No  Yes If yes, please give details: \_\_\_\_\_

Name of Medication (Prescription or Otherwise)	Dates Used	Quantity Taken	Frequency Taken

**(5) Has a pulmonary function test (breathing test) ever been done?**  No  Yes  
 If yes, please provide most recent date: \_\_\_\_\_ Are any test results known? \_\_\_\_\_

**(6) What is the proposed insured's build?** Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**(7) Has a Chest X-ray been done?**  No  Yes Date: \_\_\_\_\_ Findings: \_\_\_\_\_

**(8) Has a ECG been done recently?**  No  Yes Date: \_\_\_\_\_ Findings: \_\_\_\_\_

**(9) Are there any other medical conditions affecting the proposed insured? If yes, please describe in detail below:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
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