

COLITIS & CROHN'S 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 first diagnosis:** _____ **Date of most recent episode:** _____ **Total Number. of episodes:** _____
Number of episodes past six months: _____ **Longest duration:** _____ (days, weeks, months)

(2) **Number of episodes past five years:** _____ **Longest duration:** _____ (days, weeks, months)
Would your Doctor characterize the condition as: Mild Moderate Severe

(3) **What condition(s) have been diagnosed?**

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Irritable Bowl Syndrome | <input type="checkbox"/> Frequent colon spasms | <input type="checkbox"/> Pancolitis | <input type="checkbox"/> Ulcerative Proctitis |
| <input type="checkbox"/> Mucous Colitis | <input type="checkbox"/> Spastic Colitis | <input type="checkbox"/> Catarrhal Colitis | <input type="checkbox"/> Ulcerative Proctosigmoiditis |
| <input type="checkbox"/> Chronic Proctitis (rectum) | <input type="checkbox"/> Chronic Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Other: _____ |

(4) **What part of your GI tract is involved?** _____

(5) **Is the proposed insured taking any medications? If yes:**

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

(6) **Has the proposed insured ever been hospitalized for the condition? If yes, please provide date(s):** _____

(7) **Has surgery been recommended? If yes, when will the surgery be completed?** _____

(8) **Has surgery been done? If yes, please list dates and type of surgery(ies):** _____

(9) **Has the proposed insured ever been disabled because of the condition: If yes, dates:** _____

(10) **Does the proposed insured have any other medical conditions that may affect underwriting? If yes, please provide details:**
