

MEDICAL HISTORY QUESTIONNAIRE: CROHN'S DISEASE

Client Name: _____ Date of Birth: _____

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

Tobacco Usage:

☐ Never

☐ Former

☐ Current

Date Stopped: _____

Type: _____

Coverage Information:

Type: ☐ Term

☐ WL

☐ UL

☐ VUL

☐ IUL

☐ 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: _____
