# 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. How often do they have attacks? _____

5. Date of last attack: _____

6. Type of treatment: Diet or medication? _____

7. 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): _____

8. Please list current medications:

| NAME OF MEDICATION | DOSAGE | REASON |
|---|---|---|
| | | |
| | | |
| | | |

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

If yes, please provide details: _____

_____

_____

_____