MEDICAL HISTORY QUESTIONNAIRE: DEPRESSION

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. Please indicate: Number of episodes: _____ Date of last episode: _____

3. Has the client been hospitalized for psychiatric treatment? ☐No ☐Yes

If yes, please provide details: _____

_____

_____

4. Does the client have a history of any of the following conditions? (check all that apply)

☐ Personality disorder ☐ Psychotic disorder ☐ Suicidal thought/attempt

☐ Substance abuse (alcohol or drugs, if yes, complete questionnaire)

☐ Other psychiatric disorder

If yes, please provide details: _____

_____

_____

5. Is the client currently working? ☐ No ☐ Yes

If yes, list occupation: _____

6. Has any time been lost from work as a result of condition? ☐ No ☐ Yes

If yes, please provide details: _____

_____

_____

7. Please list current medications:

NAME OF MEDICATION	DOSAGE	REASON

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

If yes, please provide details: _____

_____

_____

_____