



# ASTHMA

## PRELIMINARY UNDERWRITING QUESTIONNAIRE

Client:

Gender: M F DOB:

Height: Weight:

Coverage Desired?

Amount?

Plan Desired?

*If your client has a history of Asthma, please answer the following:*

### ASTHMA HISTORY

1. What was the date of initial diagnosis?
2. Has your client ever been hospitalized for this condition? Yes No  
*If yes, please give details?*
3. How often does your client see a physician for asthma?
4. Does your client have any abnormalities on an ECG or x-ray? Yes No  
*If yes, please give additional details and dates:*
5. Has your client ever smoked?  
Yes, and currently smokes (amount/day)  
Yes, smoked in the past but quit (date)  
Never Smoked
6. Has a pulmonary function test (a breathing test) ever been done?  
Yes, please give most recent test results  
No

### CURRENT STATE

7. Is your client on any other medications (include inhalers) or any medication taken on an "as needed" basis?  
Yes, please give details  
No
8. Does your client have any other major health problems (ex: heart disease, etc.)? Yes No  
*If yes, please give details:*

### ADDITIONAL COMMENTS

Do you have any additional comments?

Advisor:

Date:

For more information, contact:  
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