



### Life Insurance Health Screening Questionnaire

Client Name: \_\_\_\_\_

Agent Name: Steve Shorr Insurance

Proposed Death Benefit Amount: \_\_\_\_\_

Type of Policy Seeking: \_\_\_\_\_

Life Insurance is about protecting the things that are important to your clients. When considering life insurance for your client, you must think about their health. It is their health, not their pocketbook, that determines if life insurance makes sense.

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Do you use tobacco products? Yes No Type: \_\_\_\_\_  
In past 12 months? Yes No How much? \_\_\_\_\_

Have you previously been declined for life insurance? Yes No  
Reason for decline: \_\_\_\_\_

Are you receiving Worker's Compensation/Disability? Yes No

Reason for the Disability: \_\_\_\_\_

Type of Disability Income: \_\_\_\_\_

Actively working? Yes No If no, please explain? \_\_\_\_\_

Does the client have any family history (parent, sibling) of death before age 70 due to cardiovascular, cerebral vascular disease, diabetes, or cancer?

If yes, please explain: \_\_\_\_\_

Within the last 5 years has the client had a moving violation, reckless driving, or DUI/DWI?  
If yes, please explain: \_\_\_\_\_

Any prior convictions? If so, please explain: \_\_\_\_\_

Does the client participate in any dangerous activities/avocations (scuba diving, racing, skydiving, etc)?  
If yes, please explain: \_\_\_\_\_

Is the client intending to travel to any foreign country (excluding Canada)?  
If yes, please explain including length of stay: \_\_\_\_\_

U.S. Citizen? Yes No Green Card? Yes No Applying for Citizenship? Yes No

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Phone: [Redacted] [Redacted] [Redacted]  
310.519.1335 Steve@SteveShorr.com

List all prescription medications taken over the past 12 months.

1. Medication: \_\_\_\_\_ Amount \_\_\_\_\_: \_\_\_\_\_ Currently Taking? \_\_\_\_\_  
How Long Taking: \_\_\_\_\_ Reason Prescribed: \_\_\_\_\_
2. Medication: \_\_\_\_\_ Amount \_\_\_\_\_: \_\_\_\_\_ Currently Taking? \_\_\_\_\_  
How Long Taking: \_\_\_\_\_ Reason Prescribed: \_\_\_\_\_
3. Medication: \_\_\_\_\_ Amount \_\_\_\_\_: \_\_\_\_\_ Currently Taking? \_\_\_\_\_  
How Long Taking: \_\_\_\_\_ Reason Prescribed: \_\_\_\_\_
4. Medication: \_\_\_\_\_ Amount \_\_\_\_\_: \_\_\_\_\_ Currently Taking? \_\_\_\_\_  
How Long Taking: \_\_\_\_\_ Reason Prescribed: \_\_\_\_\_
5. Medication: \_\_\_\_\_ Amount \_\_\_\_\_: \_\_\_\_\_ Currently Taking? \_\_\_\_\_  
How Long Taking: \_\_\_\_\_ Reason Prescribed: \_\_\_\_\_

Have you ever been diagnosed by a licensed physician as having any of the following conditions?

(Circle all that apply)

Yes

No

**If yes, please fill out third page.**

AIDS/HIV Positive  
Alzheimer's Disease  
Cancer (type)  
COPD (emphysema)  
Strokes  
Coronary Artery Disease  
Multiple Sclerosis  
Crohn's Disease  
Depression/Anxiety  
Diabetes (type)

Parkinson's Disease  
Alcohol Abuse  
Drug Abuse  
Epilepsy (type & date of last)  
Cirrhosis  
Asthma  
Hepatitis (type)  
Irregular Heart Rate/ Palpitations  
Kidney Disease/Failure  
Lupus (type)

Peripheral Vascular Disease  
Rheumatoid Arthritis  
Sleep Apnea  
High Blood Pressure (readings)  
High Cholesterol (controlled)  
Heart Attack  
Aneurysm (location, size, operated?)  
Organ Transplants (type)  
Cardiovascular Disease

If you answered "YES" to any of the previous questions, provide full details here.

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Treatments: \_\_\_\_\_ Prognosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Treatments: \_\_\_\_\_ Prognosis: \_\_\_\_\_

Medications: \_\_\_\_\_

Give details on any surgery or procedure. (i.e., angioplasty, bypass surgery, pacemaker, defibrillator)

Procedure: \_\_\_\_\_ Date: \_\_\_\_\_

Treatment or Therapy: \_\_\_\_\_ Residual

Problems: \_\_\_\_\_

**List additional medications, diagnosis, or procedures  
on a separate page and attach to this document.**

Phone: \_\_\_\_\_

## Typical Health Concerns and Medications for Life Insurance Prospects

### Asthma

1. Frequency of attacks or hospitalizations?
2. Any oral steroids including inhalers that are steroidal?
3. Smoker?
4. Stable pulmonary function tests?
5. Any diagnosis of COPD or emphysema?
6. How long diagnosed?

### Cancer

1. Where cancer originated?
2. What stage of cancer, 1-4? 4 being metastasis and uninsurable.
3. What kind of treatment and last date of treatment, if fully recovered (including surgery, radiation or chemotherapy?)
4. When diagnosed?
5. PSA for prostate cancer <1?
6. If melanoma need Clark level and depth of invasion?

### COPD/Emphysema

1. What medications, inhalers, and nebulizer?
2. Does the client smoke?
3. Need to know if the client has stable pulmonary function tests?
4. Any hospitalizations?
5. Any limitations or shortness of breath?
6. Any oxygen use, daily steroid use or hospitalizations?
7. When diagnosed?

### Crohn's disease

1. When diagnosed?
2. What treatment or meds is the client using?
3. How frequent are flare-ups or hospitalizations?
4. Wt stable?

### Diabetes

1. What type, 1 or 2?
2. When diagnosed?
3. How well controlled, last hemoglobin A1C?
4. Any diabetic complications (neuropathy (nerve damage), retinopathy (eye), nephropathy (kidney damage), or circulatory problems?)
5. Wt and ht stable and w/in the guidelines?
6. What medications, oral or insulin?
7. Any heart conditions?

### Heart disease

1. Any heart surgeries, when and what type, bypass (# of bypasses), angioplasty, pacemaker, or heart valve replacement?
2. Recovered?
3. What medications taking?
4. Any congestive heart failure/atrial fibrillation/heart attack/chest pains.
5. Is the client having regular follow-ups and/or testing (last seen and test results)

### Lupus

1. What type? Discoid or systemic?
2. When diagnosed?
3. If systemic, what organs affected and how severe are they affected?
4. What treatment or meds is the client using?
5. How many flare-ups or hospitalizations?

### Stroke/CVA/TIA

1. How many strokes?
2. When was the episode?
3. Any residuals, such as numbness, weakness, pain, slurred speech, or visual impairment?
4. Any limitations that require cane or assistance?
5. Any findings on a CT of white matter changes, small vessel disease, ischemic changes, micro vascular changes and lacunar infarcts?
6. Any cognitive abnormalities?

### Sleep Apnea

1. When diagnosed?
2. Severity of the condition?
3. Does the client use a CPAP machine? Is the machine hooked to oxygen? If it is then companies will decline.
4. Any other treatment?
5. Stable pulmonary function tests?