



**CHOLESTEROL
(LIPID) ELEVATIONS QUESTIONNAIRE**

Agent: _____ Phone: _____ Fax: _____
 Proposed Insured Name: _____ M F Date of birth: _____
 Face Amount: _____ Max. Premium: \$ _____ / year UL WL Term Survivorship
 Do you currently smoke cigarettes? Y N If no, did you ever smoke: Never Quit (Date): _____
 Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): Y N
 If Yes, please provide details: _____
 When did you last use any form of tobacco: ____ (Month) ____ (Year) Type used last: _____
 Height: ____ ft. ____ in. Weight: _____ lbs.

(1) Please provide date of diagnosis: _____

(2) Please provide approximate readings of known cholesterol levels:

Total Cholesterol	
LDL (Bad Cholesterol)	
HDL (Good Cholesterol)	
Triglyceride Level	

Total Cholesterol / HDL Ratio	
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(3) Does the proposed insured take any medications to control the blood pressure or for any other reason?

Name of medication (prescription or otherwise)	Dates used	Quantity taken	Frequency taken

(4) Is there any family history of heart disease, circular disorder or stroke?

	Age (if living)	Age at death	Cause of death if deceased:	History of heart disease or circulatory disorder?	History of stroke?
Mother				Yes No	Yes No
Father				Yes No	Yes No
Sister(s)				Yes No	Yes No
Brother(s)				Yes No	Yes No

(5) Does the proposed insured have a history of the following (if yes, check and describe in item six below):

- Elevated blood pressure Diabetes Kidney Disease Heart disease Being overweight
 Stroke TIA Aneurysm Peripheral vascular disease

(6) Please advise of any additional information that may help us provide you with a more accurate preliminary assessment:

