



# EMG Insurance Brokerage

## HIGH BLOOD PRESSURE (HYPERTENSION) 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 dates and readings of known blood pressure measurements:

Approximate date(s):	Systolic/Diastolic reading(s):

Approximate date(s):	Systolic/Diastolic reading(s):

(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 known family history relating to kidney/cardiovascular disease? If yes, please describe:

	Age (if living)	Age (at death)	Cause of death, if deceased:	History of heart disease or circulatory disorder?	History of stroke?
Mother				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sister(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Brother(s)				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

- Elevated cholesterol     Diabetes     Kidney Disease     Heart disease     Being overweight  
 Stroke     TIA     Aneurism     Prerepheral vascular disease

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

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