



**CHRONIC OBSTRUCTIVE  
PULMONARY DISEASE 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) *Date of diagnosis:* \_\_\_\_\_

(2) *Type of lung disease diagnosed with Chronic Obstructive Pulmonary Disease (COPD):*

Asthma Chronic Bronchitis Emphysema Restrictive lung disease Other: \_\_\_\_\_

(3) *Has the proposed insured ever been hospitalized for the condition?* No Yes Date(s): \_\_\_\_\_

(4) *Is the proposed insured taking medications (incl. inhalers and oxygen)?* No Yes If yes, please give details:

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(5) *Has a pulmonary function test (breathing test) ever been done?* No Yes

If yes, please provide most recent date: \_\_\_\_\_ Are any test results known? \_\_\_\_\_

(6) *What is the proposed insured's build?* Height: \_\_\_\_\_ Weight: \_\_\_\_\_

(7) *Has a Chest X-ray been done?* No Yes Date: \_\_\_\_\_ Findings: \_\_\_\_\_

(8) *Has a ECG been done recently?* No Yes Date: \_\_\_\_\_ Findings: \_\_\_\_\_

(9) *Are there any other medical conditions affecting the proposed insured?* If yes, please describe in detail below:

\_\_\_\_\_  
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