

# TIC Financial Services

## BUILD AND BLOOD PRESSURE QUESTIONNAIRE

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Proposed Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F  
Tobacco Use:  Yes  No Amount: \_\_\_\_\_ Height: \_\_\_\_\_ Ft. In. Weight: \_\_\_\_\_  
Broker's Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Proposed Insured please answer the following:

1. What was your weight 12 months ago?
2. If you have elevated blood pressure when did you first notice it?
3. Please provide your current blood pressure reading:
4. What have your blood pressure readings been over the last 24 months:

|       |          |       |          |
|-------|----------|-------|----------|
| Date: | Reading: | Date: | Reading: |
| Date: | Reading: | Date: | Reading: |
| Date: | Reading: | Date: | Reading: |

5. Do you know your Cholesterol level?  No  Yes, level: \_\_\_\_\_  
HDL/Cholesterol ratio: \_\_\_\_\_

6. Have you been diagnosed with or had any of the following symptoms:

|  |  |                                   |   |
|--|--|-----------------------------------|---|
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/TIA       |
| <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Proteinuria   | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Pulse Disorder    | <input type="checkbox"/> Abnormal EKG  |                                   |   |

Details:

7. Have you had an EKG done within the last 5 years?  No  Yes, Date: \_\_\_\_\_

Results:

8. Do you exercise regularly?  No  Yes

Details::

9. Are you on any medication(s)?  No  Yes, Name(s) and dosage(s): \_\_\_\_\_

10. Date you last consulted your physician: \_\_\_\_\_

11. Name and address of your physician(s): \_\_\_\_\_
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Date: \_\_\_\_\_ Proposed Insured's Signature: \_\_\_\_\_