

TIC Financial Services
RESPIRATORY QUESTIONNAIRE

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: _____

Proposed Insured please answer the following:

1. Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Bronchitis	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Asthma	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Emphysema	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Chronic cough	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Pneumonia	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Sleep Apnea	Date of first attack: _____	Date of last attack: _____
<input type="checkbox"/> Other:	Date of first attack: _____	Date of last attack: _____

2. How often do your attacks occur, and date of last attack?

3. How long do your attacks last?

4. Please give details of your attacks?

Mild Moderate Severe Coughing of blood Coughing of phlegm

5. Have you ever lost any time from work due to any of these conditions?

No Yes, How long, and why: _____

6. Have you ever experienced any of the following?

Shortness of breath Wheezing
 Problems with climbing stairs or exercising Other respiratory/lung problems

Details: _____

7. Have you ever been hospitalized or had to go to the emergency room?

No Yes, Most recent date: _____

Diagnosis: _____

8. Have you ever used tobacco products? No Yes, Most recent date: _____

Type: _____ Amount: _____ How long: _____

9. Are you or have you ever been on any medication(s) and/or treatment(s)? No Yes

Name(s) and dosage: _____

10. Date you last consulted your physician: _____

11. Name and address of your physician(s): _____

Date: _____ Proposed Insured's Signature: _____