DIXON WELLS

Comprehensive Medical Questionnaire

Full Name: _____

Date of Birth: _____ Male ☐ Female ☐

Full Name: _____

Date of Birth: _____ Male ☐ Female ☐

Home address: _____

City, State, Zip: _____

Preferred Phone Number: _____ Email Address: _____

Plan of Insurance Requested:

Individual: ☐ Term ☐ UL ☐ WL Survivorship: ☐ SUL ☐ SVUL

Term Length: ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30

New Coverage Amount Requested: $_____

In-Force Life Coverage Amount: $_____

Nicotine Use (any tobacco use within the last five years):

- ☐ None
- ☐ Cigarettes How much and how often? _____
- ☐ Cigars How much and how often? _____
- ☐ Chewing Tobacco How much and how often? _____
- ☐ Nicotine Gum/Patch How much and how often? _____
- ☐ Other (specify) How much and how often? _____

If you have used any of the above products, when did you stop using them? _____

☐ Yes ☐ No Do you do any foreign travel outside of the US or Canada?

☐ Yes ☐ No Do you participate in flying (airplanes, helicopters or hot air balloons), scuba diving, or racing?

☐ Yes ☐ No Have you ever been rated or declined for insurance? If yes, please provide details: _____

_____

Health Conditions: Have you ever been treated or diagnosed with any of the following:

☐ Heart Disease ☐ Stroke ☐ COPD ☐ Cancer ☐ Diabetes

☐ Lupus ☐ MS ☐ Asthma ☐ Sleep Apnea ☐ Arthritis

☐ Alcohol Abuse ☐ Drug Abuse ☐ High Blood Pressure ☐ Depression

Please give as much detail as possible regarding any conditions you check, including date of diagnosis and treatment. If you have any conditions not listed, please give detail in space provided. _____

_____

_____

_____

Current medications: _____

_____

Height: _____ Weight: _____

Family Medical History: Do you have any family history (parenting or sibling) of cardiovascular disease, cerebrovascular disease, diabetes or cancer prior to age 60?

☐ Yes ☐ No

If Yes, provide full details with impairment, age at onset and age at death if deceased:

Father: _____

Mother: _____

Siblings: _____