

MEDICAL HISTORY QUESTIONNAIRE: ULCERATIVE COLITIS

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage:

- Never
 Former
 Current

Date Stopped: _____
 Type: _____

Coverage Information:

- Type: Term UL IUL
 WL VUL Survivorship

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance

Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis _____

2. How often does your client visit his/her physician? _____

3. Date of last visit: _____

4. Type of Inflammatory Bowel Disease:

- Chronic Ulcerative Colitis
 Chronic Proctitis (inflammation in rectum only) _____

5. Please check if your client has (had) any of the following:

- Hospitalizations for this disorder (list dates): _____
 Surgery for this disorder (list dates): _____
 Colonoscopy (date of most recent): _____

6. Please list current medications

Name of Medication	Dosage	Reason

7. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____

