

## QUICK QUOTE FOR PULMONARY DISEASE

**CLIENT:** NAME \_\_\_\_\_ / ☐ M ☐ F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS. ☐ UL ☐ TERM YRS. LVL \_\_\_\_\_

TOBACCO USE ☐ NO ☐ YES, TYPE \_\_\_\_\_ / REPLACEMENT ☐ YES ☐ NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

FAMILY HISTORY –  
AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED, PROVIDE RELATION, AGE AND CAUSE OF DEATH \_\_\_\_\_

HAVE ANY OF YOUR FAMILY MEMBERS BEEN DIAGNOSED WITH CANCER, DIABETES OR HEART DISEASE PRIOR TO AGE 60? IF YES, PROVIDE RELATION, ILLNESS AND AGE OF ONSET \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? ☐ NO ☐ YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ RESULTS \_\_\_\_\_

DATE OF LAST RESTING EKG \_\_\_\_\_ RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (EXAMPLE 140/80) \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE? ☐ NO ☐ YES

LAST TOTAL CHOLESTEROL READING AND HDL READING \_\_\_\_\_ / ARE YOU TREATED FOR CHOLESTEROL? ☐ NO ☐ YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**CPS OFFICE ONLY:** ENTER OFFICE NAME/LOCATION \_\_\_\_\_ FAX \_\_\_\_\_

1. PLEASE NOTE TYPE OF LUNG DISEASE:

- ☐ CHRONIC BRONCHITIS  
☐ EMPHYSEMA  
☐ RESTRICTIVE LUNG DISEASE  
☐ ASTHMA

2. PLEASE PROVIDE DATE OF INITIAL DIAGNOSIS:

\_\_\_\_\_

3. HAS THE CLIENT EVER BEEN HOSPITALIZED FOR THIS CONDITION?

☐ NO ☐ YES, DATE \_\_\_\_\_

4. HAS THE CLIENT EVER SMOKED?

☐ YES, CURRENTLY SMOKES \_\_\_\_\_ (AMOUNT/DAY)

☐ YES, SMOKED IN THE PAST BUT QUIT \_\_\_\_\_ (DATE)

☐ NO, NEVER SMOKED

5. IS THE CLIENT ON ANY MEDICATION, AN INHALER OR OXYGEN TANK FOR THE DISEASE?

☐ NO ☐ YES, DETAILS \_\_\_\_\_

\_\_\_\_\_

6. HAS THE CLIENT HAD A RECENT PULMONARY FUNCTION (BREATHING) TEST?

☐ NO ☐ YES, RESULTS:

FVC: \_\_\_\_\_

FEV1: \_\_\_\_\_

7. DOES THE CLIENT HAVE ANY ABNORMALITIES ON A CHEST X-RAY OR CT SCAN?

☐ NO ☐ YES, PROVIDE DETAILS AND DATES OF TESTING:

\_\_\_\_\_

\_\_\_\_\_

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDICATIONS AND VITAMINS TAKEN:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_