IAMS | Insurance Agency Marketing Services, Inc.

Health Screening Questionnaire

Agent Name:_____

Client Name:_____ **Gender:** ☐ **Male** ☐ **Female**

Height:_____**ft.** _____**in.** **Weight**_____**lbs.** **Date of Birth:**_____ /_____ / _____

Ever use tobacco? ☐ **Yes** ☐ **No** **Last Used:**_____ **Type:**_____

Type of Plan: ☐ **Term** **Years:**_____ ☐ **UL** ☐ **Indexed UL** ☐ **Whole Life** ☐ **Permanent**

☐ **Permanent Death Benefit:** ☐ **(A) Level** ☐ **(B) Increasing**

Face Amount: **$**_____ **Single Premium: $**_____

Annual Premium: $_____ **Monthly Benefit: $**_____

Have you previously been declined or rated for life insurance? ☐ **Yes** ☐ **No**

If yes, reason for decline or rating:_____

_____

Are you receiving Worker's Compensation/Disability? ☐ **Yes** ☐ **No**

Are you disabled? ☐ **Yes** ☐ **No** **Reason for disability:** _____

Actively working? ☐ **Yes** ☐ **No** **If no, please explain:**_____

_____

U.S. Citizen? ☐ **Yes** ☐ **No** **Green Card?** ☐ **Yes** ☐ **No** **Applying for citizenship? Yes** ☐ **No** ☐

Within the last 5 years has the client had a moving violation, reckless driving, or DUI/DWI? ☐ **Yes** ☐ **No** **If yes, please explain:**_____

_____

Felony convictions or criminal history? ☐ **Yes** ☐ **No** **If yes, please explain:**_____

_____

Does the client participate in any dangerous activities/avocations (scuba diving, racing, sky diving, etc.)? ☐ **Yes** ☐ **No** **If yes, please explain:**_____

_____

Is the client intending to travel to any foreign country? ☐ **Yes** ☐ **No** **If yes, please explain (including length of stay):** _____

1505 North 210th Street, Elkhorn, NE 68022 | Phone (800) 255-5055 | Fax (402) 330-7296 | www.iamsinc.com

IAMS | Insurance Agency Marketing Services, Inc.

Health Screening Questionnaire

1. Does the client have any family history (parent, sibling) of death before age 65 due to cardiovascular, cerebral vascular disease, diabetes, or cancer? ☐ **Yes** ☐ **No**

If yes, please explain:_____

_____

_____

2. Have you ever been diagnosed by a licensed physician as having any of the following conditions?

☐ **AIDS/HIV Positive**	☐ **ALS (Lou Gehrig's Disease)**	☐ **Alzheimer's Disease**
☐ **Crest**	☐ **Mental Retardation**	☐ **Metastatic Cancer**
☐ **Multiple Myeloma**	☐ **Cystic Fibrosis**	☐ **Multiple Strokes (TIA)**
☐ **Muscular Distrophy**	☐ **Multiple Sclerosis**	☐ **Neurogenic Bladder**
☐ **Scleroderma**	☐ **Parkinson's Disease**	☐ **Post Polio Paralytic**
☐ **Demetial/Confusion**	☐ **Spinal Cord Injury**	☐ **Cerebral Atrophy**
☐ **Kidney Failure**	☐ **Liver Cirrhosis**	☐ **Schizophrenia**

2a. If you checked any boxes in the previous question, please check all that apply. If not, skip this section:

☐ **Amputation**	☐ **Amnesia**	☐ **Autoimmune Disorder**
☐ **Angioplasty/Bypass Surgery**	☐ **Dizziness**	☐ **Back Disorder/Surgery**
☐ **Arthritis**	☐ **Epilepsy/Seizures**	☐ **Blindness/Degeneration**
☐ **Drug or Alcohol Abuse**	☐ **Falls**	☐ **Blood Disorder**
☐ **High Blood Pressure**	☐ **Heart Problems**	☐ **Bronchitis/Asthma**
☐ **Joint Replacement/Fractures**	☐ **Aneurysm**	☐ **Hepatitis**
☐ **Fibromyalgia Disorder**	☐ **Cancer**	☐ **Mental/Nervous**
☐ **Neurological Disorder Disease**	☐ **COPD/Emphysema**	☐ **Peripheral Vascular**
☐ **Urinary Incontinence**	☐ **Crohn's Disease**	☐ **Depression**
☐ **Respiratory Disorders**	☐ **Stroke/TIA**	

☐ **Elevated PSA or Prostate Disorders:** *PSA Levels_____

☐ **Osteoporosis with Fractures:** *Bone Density Test T-score_____

☐ **Diabetes Mellitus:**

Type_____*Insulin units per day_____Recent A1C Level_____Blood Sugar Level_____

1505 North 210th Street, Elkhorn, NE 68022 | Phone (800) 255-5055 | Fax (402) 330-7296 | www.iamsinc.com

IAMS | Insurance Agency Marketing Services, Inc.

Health Screening Questionnaire

3. If you checked any boxes in the previous 2 questions, provide details here. If not, skip this section:

Reason:_____Date:_____

Treatment or Therapy:_____

Residual Problems:_____

Reason:_____Date:_____

Treatment or Therapy:_____

Residual Problems:_____

Reason:_____Date:_____

Treatment or Therapy:_____

Residual Problems:_____

4. List all prescription medications taken over the past 12 months.

1. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

2. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

3. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

4. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

5. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

6. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____

7. Medication:_____ Amount:_____Currently Taking? ☐

How Long Taking:_____ Reason Prescribed:_____