



Diversified Marketing Group, Inc. RESPIRATORY QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
 Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
 Broker's Name: _____ Face Amount: _____
 BGA: _____ 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): _____

Underwriter's Notes: _____

Date: _____ Proposed Insured's Signature: _____