

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: _____

