HEALTH INSURANCE ASSESSMENT QUESTIONNAIRE

Applicant Name: _____ D.O.B _____
Spouse Name: _____ D.O.B _____
Child Name: _____ D.O.B _____
Child Name: _____ D.O.B _____
Child Name: _____ D.O.B _____
Child Name: _____ D.O.B _____

Is any family member pregnant? Yes ☐ No ☐ **If so, when is the due date?** _____
Have there been any complications (if so, please provide details)? _____

Have you or any family member smoked cigarettes or used tobacco of any kind in the last 12 months? Yes ☐ No ☐

_____
_____
_____

List all medications taken and dosages:

Name _____ Name _____
Medication _____ Medication _____

Please explain answers to any questions you checked "yes" to above:

Name:
Diagnosis of Condition:
Duration of Condition:
Type of Treatment:
Medications:
Any Current Symptoms/problems:

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