

# GASTROINTESTINAL QUESTIONNAIRE

Rohrer & Associates

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ State: \_\_\_\_\_ Sex: M / F  
Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In. \_\_\_\_\_ Weight: \_\_\_\_\_ Face Amount: \_\_\_\_\_  
Tobacco use in the past 5 years: No Yes Details: \_\_\_\_\_  
Producer: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Proposed Insured please answer the following:

1. Date you first experienced symptoms:
2. What is your actual diagnosis?
3. Date of your last attack?
4. How often do you have attacks?
5. Are the attacks becoming more frequent? Yes No  
Details: \_\_\_\_\_
6. Do you experience any of the following?  
Black stool Vomiting Bleeding Relieved by eating
7. Have you had any weight loss in the past 6 months? Yes No  
Details: \_\_\_\_\_
8. Have you had any surgery(ies) for this disease? Yes No  
Details & Dates: \_\_\_\_\_
9. How often do you have a full work-up for your gastrointestinal problem?
10. What tests or procedures does the complete work-up include?
11. Are you on any medication(s)? Yes No  
Name(s) and dosage(s): \_\_\_\_\_
12. Name, address & phone number of your physician(s) and the date last consulted:

---

Additional Information (please use reverse side for additional space):

Date: \_\_\_\_\_ Insured's Signature: \_\_\_\_\_