

RESPIRATORY 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. Have you ever been diagnosed with any of the following (please circle all that apply)?:
Asthma Date of first attack: Date of last attack:
Bronchitis Date of first attack: Date of last attack:
Chronic Cough Date of first attack: Date of last attack:
Emphysema Date of first attack: Date of last attack:
Pneumonia Date of first attack: Date of last attack:
Restrictive Lung Disease Date of first attack: Date of last attack:
Sleep Apnea Date of first attack: Date of last attack:
Other: Date of first attack: Date of last attack:
2. How often do your attacks occur?
3. How long do your attacks last?
4. Please give details of your attacks (please circle all that apply):
Mild Moderate Severe Coughing of blood Coughing of phlegm
5. Have you ever lost any time from work due to any of these conditions? Yes No
Details:
6. Have you ever experienced any of the following (please circle all that apply)?
Shortness of breath Problems with climbing stairs or exercising
Wheezing Other respiratory/lung problems
Details:
7. Have you ever been hospitalized or had to go to the emergency room? Yes No
Details:
8. Have you ever had a pulmonary function test (a breathing test)? Yes No
If yes, please give most recent test results:

9. Have you had any abnormalities on your ECG or x-ray? Yes No

Details:

10. Are you on any medication(s)? Yes No

Name(s) and dosage(s):

11. 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: _____