FERNEDING INSURANCE HEALTH HISTORY QUESTIONNAIRE

Contact Name:_______________________________________Date___________________

Home Phone:_____________________WorkPhone:______________________________

Cell Phone: ________________________ Fax Phone: _______________________________

Email; ___________________________ Best time to contact: ______________________

Applicant:

Name: ____ Sex: ______________

Street Address:____

City:_______________________________________ State:_ ___ Zip: ______________

Date of Birth: ____/____/_______

Height: _____feet ___inches Weight:_____ pounds

Nicotine/Tobacco use: none [ ] cigarettes [ ] (number per day______) Other [ ] Explain:

Other than regular “check ups” have you visited a physician, clinic or hospital for any reason in the last five years? Yes [ ] No [ ]
If “Yes” please explain and give dates.

Have you ever been diagnosed or treated for, or engaged in any of the following:
High blood pressure, cancer, diabetes or heart disorder? ☐ Yes ☐ No
Hazardous activities (scuba diving, piloting, etc.)? ☐ Yes ☐ No

Medications currently taking:

Medication	Dosage	Frequency	Diagnosis	Onset

Please explain any ongoing health issues, the prognosis, and any lifestyle changes anticipated: