

MEDICAL HISTORY QUESTIONNAIRE: ULCERATIVE COLITIS

Client Name: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Height: _____

Weight: _____

Tobacco Usage:

Coverage Information:

☐ Never

Type: ☐ Term ☐ UL ☐ IUL

☐ Former

Date Stopped: _____

☐ WL ☐ VUL ☐ Survivorship

☐ Current

Type: _____

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: _____
