



# Trinity Life Insurance Company

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## **ASTHMA QUESTIONNAIRE – Completed by Applicant**

NAME	DATE OF BIRTH	POLICY NUMBER
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1. (a) Height? \_\_\_\_\_ ft \_\_\_\_\_ in (b) Weight? \_\_\_\_\_ lbs  
(c) Weight one year ago? \_\_\_\_\_ lbs

2. Date Asthma diagnosed. \_\_\_\_\_ Age at onset? \_\_\_\_\_

3. Name and address of Doctor supervising your Asthma program?

Name: \_\_\_\_\_ Address: \_\_\_\_\_

How long have you been under his care? \_\_\_\_\_ Date of Last Visit? \_\_\_\_\_

How often do you consult him for examination and advise? \_\_\_\_\_

Number tests positive? \_\_\_\_\_

4. How many times a year do you have an attack? \_\_\_\_\_ Date of Last Attack? \_\_\_\_\_

5. Are lungs clear between attacks? (Wheezing or rales present? How severe?)

6. What medications are you taking? What is the dosage and frequency? How long have you been taking medication for Asthma? Any changes in medication or any other treatments?

7. Has your doctor done any diagnostic studies (Pulmonary function tests, x-rays, allergy tests, bronchoscopy?) When and what were the findings.

8. Have you ever been hospitalized during an attack? If yes, give details and name and address of hospital.

9. Any complications such as loss of weight, high blood pressure, evidence of chronic bronchitis, other lung disease or fungus infection present?

10. Any history of disability due to Asthma? Loss of time from work due to Asthma? Please give details:

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_