



Trinity Life Insurance Company

ADMINISTRATIVE OFFICE: PO BOX 5205 • FRANKFORT, KY 40602-5205
Phone: (866) 440-1357 • Fax: (502) 227-7205

ASTHMA QUESTIONNAIRE – Completed by Applicant

NAME	DATE OF BIRTH	POLICY NUMBER
------	---------------	---------------

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: _____