MEDICAL HISTORY QUESTIONNAIRE: ANXIETY DISORDERS

Client Name: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Tobacco Usage:

☐ Never
☐ Former Date Stopped: _____
☐ Current Type: _____

Coverage Information:

Type: ☐ Term ☐ UL ☐ IUL ☐ WL ☐ VUL ☐ Survivorship

Face Amount: _____

Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of diagnosis: _____

☐ Generalized Anxiety Disorder ☐ Panic Disorder
☐ Obsessive Compulsive Disorder ☐ Post-Traumatic Stress Syndrome
☐ Agoraphobia ☐ Other Anxiety Disorder _____

2. Indicate the number of episodes & date of last episode/recovery: _____

3. Is client on any medications? ☐ No ☐ Yes

If yes, please provide name & dosage: _____

4. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness?

☐ No ☐ Yes

If yes, please give dates and lengths of stay: _____

5. Does client have a history of any of the following associated conditions? (check all that apply)

☐ Depression ☐ Suicidal Thought/Attempt
☐ Substance Abuse (alcohol or drugs) ☐ Other psychiatric Disorder: _____

6. Is the client currently working? ☐ No ☐ Yes (occupation) _____

7. Has any time been lost from work as a result of condition? ☐ No ☐ Yes If yes, please give full details

_____

_____

8. Please list current medications:

Name of Medication	Dosage	Reason

9. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: _____

_____

_____

_____