BLACK, GOULD & ASSOCIATES, INC.

INDIVIDUAL MEDICAL QUESTIONNAIRE

APPLICANT REFERENCE: ______________________________

(confidential - please use initials)

	Gender	DOB (Age)	Height	Weight	Smoker (Yes/No)
Applicant					
Spouse					
Dependent 1					
Dependent 2					
Dependent 3					
Dependent 4					

Yes	No		Questions	APP	SP	DEP #
		1	Is diagnostic testing, an operation or any future treatment being recommended or contemplated?	☐	☐	___
		2	Is anyone pregnant?	☐	☐	___
		3	Is anyone taking any medication? If "Yes", list all medications and dosages.	☐	☐	___

Medication	Dosage	Taken for Treatment of

	Have you ever been diagnosed with or treated for:	APP	SP	DEP #
4	Chest pain, blood pressure, heart attack, other diseases of the heart or blood vessels circulatory system, or been diagnosed treated for stroke, TIA (mini-stroke) or paralysis? If yes, to blood pressure or high cholesterol, what was your last reading?_________________________	☐	☐	___
5	Psychological or mental disorder, emotional or nervous disorder, or depression?	☐	☐	___
6	Cancer, tumor or other malignancy?	☐	☐	___
7	Kidney or other organ disorder or have had or have been recommended to have an organ transplant?	☐	☐	___
8	Emphysema, other respiratory or lung diseases or breathing conditions?	☐	☐	___
9	Having AIDS or HIV or other immune system disorders?	☐	☐	___
10	Diabetes? If yes, give date of diagnosis and whether insulin or non-insulin dependent. **Please include dosage of insulin and any related problems.**	☐	☐	___
11	Arthritis? If yes, specify type, extent of disability and treatment received.	☐	☐	___
12	Been confined in a hospital, clinic, sanitarium or other medical facility?	☐	☐	___
13	Back or neck problems including spinal manipulation?	☐	☐	___
14	Crohns Disease?	☐	☐	___
15	Lupus?	☐	☐	___
16	MD or MS?	☐	☐	___
17	Drug or Alcohol Abuse?	☐	☐	___
18	Epilepsy?	☐	☐	___
19	Other?	☐	☐	___

For any "YES" answers identified above, please provide complete details below.

Question Number	Illness or Diagnosis	Date of Diagnosis	Date and Type of Treatment	Prognosis

AGENT NAME: ______________________________ **AGENT EMAIL** ______________________________

Please note, the more accurate information that is provided, the more accurate the assessment will be.

You may fax your request to at or email

Revised 3/17/2011