

## DRUG USE QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth or Age: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_/year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_  
 Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

**(1) Do you presently use any drugs other than those prescribed by a physician or those available over the counter?**

Yes  No If no, date of last drug use: \_\_\_\_\_ If yes, please complete table:

Type	Usual Quantity	Frequency of Use	How taken? IV?	Dates: From - To

**(2) Did you ever use other drugs or more drugs than you currently use?**  Yes  No If yes, please complete table:

Type	Usual Quantity	Frequency of Use	How taken? IV?	Dates: From - To

**(3) Are you currently attending meetings of A.A. or similar recovery groups?**  Yes  No Dates: \_\_\_\_\_

**(4) Have you ever been treated for excessive drug use?**  Yes  No If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_ Date(s): \_\_\_\_\_

**(5) Did you have any legal troubles because of drug use?**  Yes  No If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_ Date(s): \_\_\_\_\_

**(6) Have you ever experienced any of the following? If yes, please provide details below:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Blackouts                 | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Depression                                      |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Psychological Disorder | <input type="checkbox"/> Emotional Disorder                              |
| <input type="checkbox"/> Delirium Tremens          | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Kidney Disease                                  |
| <input type="checkbox"/> Protein or Blood in Urine | <input type="checkbox"/> Liver problems         | <input type="checkbox"/> Other serious medical condition (discuss below) |

**(7) Please provide any additional helpful information:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_