

Guyor Insurance Agency – Health Quote Form

Date: _____ Time: _____

Name: _____ Date of Birth _____

Height _____ Weight _____ Sex: M or F SS# _____

Home Phone# _____ Work Phone# _____

1. Any weight change of 10 lbs. or more in the last year? Yes or No If yes, how much? Reason?

2. Tobacco or nicotine use of any form (cigarette, cigar, chew, gum, etc.?) Yes or No

If yes, type, quantity, and frequency? _____

If insured quit using tobacco, how long ago? _____

3. I am a resident of the state of _____

4. Do you plan any foreign travel or residency outside of the U.S. or Canada in the next two years? Yes or No

If yes, where to and for how long? _____

5. Have you traveled outside of the U.S. or Canada in the past three years? Yes or No

If yes, provide details _____

6. In the past two years, have you flown as a pilot or co-pilot? Yes or No

7. Are you involved in any potentially hazardous or dangerous hobbies (ballooning, boxing, diving, white water rafting, rodeo events, racing, hang gliding, parachuting, etc.?) Yes or No If yes, please indicate _____

8. When operating a motor vehicle, boat, or aircraft in the last three years, have you:

A. Been convicted of any moving violations? Yes or No

B. Had an operator's license restricted, suspended, or revoked? Yes or No

C. Been convicted of operating under the influence of alcohol or drugs? Yes or No

Please provide details for any "yes" responses: _____

9. List current medications, including dosage and

frequency: _____

10. Who is your primary care physician? (name, address, phone

number): _____

11. List all other medical doctors seen in the last five years (name, address, phone number):

12. Current blood pressure and date it was last taken:

13. Total Cholesterol Level: _____ HDL: _____ LDL: _____ Chol/HDL: _____

14. Have you ever been diagnosed with cancer? Yes or No Date Diagnosed? _____

Type of Cancer? _____

15. Do you have cardiac problems? Yes or No Date Diagnosed? _____

Specific problems and treatments w/ current status: _____

16. Do you have diabetes? Yes or No

17. Date of Onset? _____ Recent A1C level: _____

Type? 1 or 2 Insulin Dependent? Yes or No

18. Have you been diagnosed with a serious condition not listed above? Yes or No

If so, please provide some general information about your condition:

19. List immediate family members (parents and siblings) ages, names, sex. If deceased, cause of death and age?

