HERMANN SONS LIFE

PHYSICAL HISTORY QUESTIONNAIRE

Name_____ Date of Birth_____

- ☐ Asthma
- ☐ Diabetes
- ☐ Urinary Disorder
- ☐ Respiratory Disorder
- ☐ Heart Disorder
- ☐ Liver Disorder
- ☐ Back Disorder
- ☐ Tumor
- ☐ Nervous Disorder
- ☐ Gastrointestinal Tract Disorder
- ☐ Reproductive Disorder
- ☐ High blood pressure
- ☐ Other

1. Describe symptoms: _____ Date of Onset: _____
2. What special tests were done? _____
3. What diagnosis was made? _____ 4. Any malignancy? _____
5. When? _____ Duration of illness? _____
6. What type treatment did you receive:
   Surgery ☐ Yes ☐ No What type? _____
   Radiation or chemotherapy ☐ Yes ☐ No Details: _____
   Medication ☐ Yes ☐ No What kind? _____ Dosage? _____
   Other ☐ Yes ☐ No Describe: _____
7. Are you currently under treatment? _____
8. Has additional treatment or surgery been suggested? _____
   _____
9. Have you been confined to the hospital?_____When? _____ How long? _____
10. Has your doctor suggested follow-up check-ups?_____
11. When did you last see your doctor? _____ Routine Check-up? ☐ Yes ☐ No
12. Have there been any recurrences? ☐ Yes ☐ No How many? _____ Frequency? _____
13. Has this problem caused you to be disabled for more than one month? ☐ Yes ☐ No Details:_____
14. Any associated diseases or complications? Explain: _____
15. Furnish blood pressure readings: Highest_____/_____ When? _____ Lowest_____/_____ When? _____
    Usual_____/_____Latest_____/_____ When? _____
16. Furnish names and addresses of all doctors and hospitals and indicate by "**X**" who has complete records.
    _____
    _____
17. Additional Comments: _____

I represent that all of the above statements and answers to all the above questions are complete and true, and I agree that they shall form a part of my application for insurance and become a part of any contract of insurance issued consequently.

_____ _____
Signature of the Proposed Insured Witness

_____ _____
Date Date