HERMANN SONS LIFE

Respiratory Questionnaire

TO BE COMPLETED BY APPLICANT
PLEASE PRINT IN BLUE OR BLACK INK ONLY

Name _____ **Date of Birth** _____

1. CHECK ALL THAT APPLY: ☐ Allergy ☐ Asthma ☐ Bronchitis ☐ Other
2. Age at onset? _____ 3. Date last noticed? _____
4. Have you had any wheezing? ☐ Yes ☐ No
   If "yes," explain: _____
   _____
5. Have you stopped any activity for a short time? ☐ Yes ☐ No
   If "yes," explain: _____
   _____
6. How often do these episodes occur in a year's time (weekly, monthly, etc.)_____
7. How long do these episodes last?_____
8. Have you ever been treated with: Antihistamines? ☐ Yes ☐ No Oxygen? ☐ Yes ☐ No
   Inhalants? ☐ Yes ☐ No Ephedrine? ☐ Yes ☐ No
   Other? _____
9. Is medication being taken now? ☐ Yes ☐ No
   If "yes," what?_____ How often?_____
10. Have you required medical attention or hospitalization? ☐ Yes ☐ No
    If "yes," give details below:

Name of Doctor or Hospital (Specify)	Address/Phone No.	Date	Treatment	Results

_____ _____
Signature of the Proposed Insured or Parent or Legal Guardian Date