

DRUG ABUSE QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
--------------	--------------	------------

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

(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: _____
