MEDICAL HISTORY QUESTIONNAIRE: ANXIETY DISORDERS

Client Name: ______________________ Date of Birth: ______________

Gender: ☐ Male ☐ Female Height: ______________ Weight: ______________

Tobacco Usage:
- ☐ Never
- ☐ Former Date Stopped: ______________
- ☐ Current Type: ______________

Coverage Information:
Type: ☐ Term ☐ UL ☐ IUL
☐ WL ☐ VUL ☐ Survivorship
Face Amount: ______________
Premium Tolerance: ______________

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of diagnosis: ______________
   - ☐ Generalized Anxiety Disorder ☐ Panic Disorder
   - ☐ Obsessive Compulsive Disorder ☐ Post-Traumatic Stress Syndrome
   - ☐ Agoraphobia ☐ Other Anxiety Disorder ______________
2. Indicate the number of episodes & date of last episode/recovery: ______________
3. Is client on any medications? ☐ No ☐ Yes
   If yes, please provide name & dosage: ______________
4. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness?
   ☐ No ☐ Yes
   If yes, please give dates and lengths of stay: ______________
5. Does client have a history of any of the following associated conditions? (check all that apply)
   - ☐ Depression ☐ Suicidal Thought/Attempt
   - ☐ Substance Abuse (alcohol or drugs) ☐ Other psychiatric Disorder: ______________
6. Is the client currently working? ☐ No ☐ Yes (occupation) ______________
7. Has any time been lost from work as a result of condition? ☐ No ☐ Yes If yes, please give full details

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8. Please list current medications:

Name of Medication	Dosage	Reason

9. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes
   If yes, please provide details: ______________

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