MEDICAL HISTORY QUESTIONNAIRE: DEPRESSION

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 ______________________

2. Please indicate: Number of episodes: __________ Date of last episode: __________

3. Has the client been hospitalized for psychiatric treatment? ☐ No ☐ Yes

If yes, please provide details: ______________________

4. Does the client have a history of any of the following conditions? (check all that apply)

☐ Personality disorder ☐ Psychotic disorder ☐ Suicidal thought/attempt

☐ Substance abuse (alcohol or drugs, if yes, complete questionnaire)

☐ Other psychiatric disorder

If yes, please provide details: ______________________

5. Is the client currently working? ☐ No ☐ Yes

If yes, list occupation: ______________________

6. Has any time been lost from work as a result of condition? ☐ No ☐ Yes

If yes, please provide details: ______________________

7. Please list current medications

Name of Medication	Dosage	Reason

8. Are there any other health issues? (Additional Questionnaires may be required) ☐ No ☐ Yes

If yes, please provide details: ______________________