

# 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: \_\_\_\_\_