Physical History Questionnaire

Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, New York 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name _____ MI ____ Last Name _____ Date of Birth _____ Social Security # _____

Check the condition to which the details in questions 2-12 relate:

1. ☐ Asthma ☐ Heart Disorder ☐ Nervous Disorder ☐ High Blood Pressure ☐ Sleep Apnea
   ☐ Diabetes ☐ Liver Disorder ☐ G. I. Tract Disorder ☐ Reproductive Disorder ☐ Other_____
   ☐ Tumor ☐ Back Disorder ☐ Urinary Disorder ☐ Respiratory Disorder
   Describe symptoms: _____ Date of onset: _____
   (If ulcer, any bleeding?) _____
   What special tests were done? _____ Results? _____
   What diagnosis was made? _____ Any malignancy?_____
   When?_____ Duration of illness? _____
2. What type treatment did you receive:

A. Surgery?	☐ Yes ☐ No	What type?
B. Radiation Therapy?	☐ Yes ☐ No	What type?
C. Medication?	☐ Yes ☐ No	What medication? Dosage?
D. Other?	☐ Yes ☐ No	Describe: If insulin, how many units? If diabetic, furnish date and results of last blood sugar test:

3. Are you currently under treatment? ☐ Yes ☐ No (If yes, give type and reason) _____
   (If no, when was treatment discontinued?) _____
4. Has additional treatment or surgery been suggested? _____
5. Have you been confined to the hospital? ☐ Yes ☐ No When? _____ How long? _____
6. When did you last consult a doctor? _____ Reason? _____
7. Have there been any recurrences? ☐ Yes ☐ No How many? _____
   Frequency? (Number of attacks in past 12 months) _____
8. Has this problem caused you to be disabled for more than one month? ☐ Yes ☐ No How long?_____
9. Amount of time missed from work/social activities in the past year related to this problem? _____
10. Have you been treated or diagnosed by a member of the medical profession for any diseases or complications related to the medical conditions disclosed in question number 1? ☐ Yes ☐ No Explain _____
11. Furnish blood pressure readings: Highest _____/ _____ When? _____
    Lowest ___/ _____ When? _____Usual _____/ _____ Latest _____/ _____ When?_____
    Furnish names and addresses of all doctors and hospitals referenced above and indicate by "X" who has complete records.
    _____
    _____
12. Additional comments_____

Agreement: I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they and this questionnaire shall form a part of my application for insurance. I agree that my failure to disclose any material fact known to me may invalidate the contract.

Proposed Insured Signature

X

Signed at (city, state) _____

Signed on (date) _____