

**TUBERCULOSIS QUESTIONNAIRE**

---

Insured's Name:	DOB:	State:	Sex: M / F
Height:      Ft.      In.      Weight:	Face Amount:		
Tobacco use in the past 5 years:    No    Yes    Details:			
Producer:	State:	Phone:	E-mail:

---

Proposed Insured please answer the following:

1.    Please list date of first diagnosis:  
      Relapse date, if any:
  
2.    Please note the site of tuberculosis present (please circle all that apply):  
          lung                    nervous system  
          bone                   kidney  
          liver                   other (state site):
  
3.    What treatment was given?    Yes    No  
      Details:
  
4.    Is your client on any other medications?    Yes    No  
      Details:
  
5.    Please circle if your client has had:  
          hospitalizations for this disorder - List date(s):  
          surgery for this disorder - List date(s):
  
6.    Have pulmonary function tests (a breathing test) ever been done?    Yes    No  
      If yes, please give most recent test results:
  
7.    Has your client smoked cigarettes in the last 12 months?    Yes    No
  
8.    Does your client have any other major health problems (i.e. heart disease, etc.)?    Yes    No  
      Details:

---

Additional Information (please use reverse side for additional space):

Date: \_\_\_\_\_ Insured's Signature: \_\_\_\_\_