Blood Pressure Questionnaire

Issued by American National Insurance Company
One Moody Plaza, Galveston, TX 77550-7947

Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business (800) 899-6806 Fax (888) 237-1012

Name: ______________________ Birthdate: ______________________ File #: ______________________

1. What was your highest blood pressure reading? __________ Please provide the date of this reading: __________
2. What was your lowest blood pressure reading? __________ Please provide the date of this reading: __________
3. Have you received treatment from a member of the medical profession for blood pressure? __________ If "yes:"
   A. Name, address and phone number of doctor(s): ______________________
   ____
   B. When did treatment begin? ______________________
   C. Last blood pressure reading and date of visit: ______________________
   D. Medication(s) prescribed and dosage: ______________________
4. Have you been diagnosed or treated by a member of the medical profession for any of the following?

   ❑ Stroke ❑ Severe headaches ❑ High cholesterol ❑ Heart Disease ❑ Diabetes ❑ Chest pains
   ❑ Circulation problems

   Please provide details. ______________________
   ____
   ____
5. Have you had any special studies performed by a member of the medical profession: (X-Rays, EKG, Lab Tests, etc.)? If yes, please provide the results: ______________________
   ____
   ____

Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I declare that the above information is true and complete to the best of my knowledge and belief, and shall form part of my application.

______________________ ______________________
Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this blood pressure history.

Chest Pain Questionnaire

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Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business (800) 899-6806 Fax (888) 237-1012

Name ______________________ Birthdate ____________ File # ____________

1. Have you ever been diagnosed with or been treated by a member of the medical profession for: **YES** **NO**
   a) Chest pain? ☐ ☐
   b) Palpitation? Skipping of heart? ☐ ☐
   c) Shortness of breath? ☐ ☐
   d) High blood pressure? ☐ ☐
2. If diagnosis or treatment for any of the conditions in question 1 was made by a member of the medical profession, and pain was experienced in the chest, was it documented as being:
   a) Middle of chest? ☐ ☐
   b) Left side of chest? ☐ ☐
   c) Left shoulder, arm or hand? ☐ ☐
   d) Both shoulders or arms? ☐ ☐
   e) Sense of pressure or constriction? ☐ ☐
   f) Sweating ☐ ☐
   g) Was it associated with:
      Exertion? Exercise? ☐ ☐
      Excitement? Strain? ☐ ☐
   h) Emergency medical care? ☐ ☐
3. For any of the conditions indicated as being diagnosed or treated by a member of the medical profession in question 1, and indicated with a "Yes" answer in question 2, please answer the following:
   a) Approximate date of first attack? ____________
   b) Date of last attack? ____________
   c) How frequent: per day, week or month? ____________
   d) Were you hospitalized? How long? ____________
   e) Were you confined at home? How long? ____________
   f) How long convalescent? ____________
   g) Date of return to work? Restrictions? ____________
   h) How many hours do you work daily? ____________
   i) What medicine are you now taking? ____________

Please give details of all Yes answers - dates, durations, results, doctors' names and addresses.

4. Please give names and addresses of all your attending doctors. ____________

5. What diagnosis was made, by a member of the medical profession, concerning your chest pain or heart condition? ____________

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Proposed Insured's Signature ____________ Date ____________

Please use the back of this sheet, if necessary, to report details which will clarify this medical history.

Diabetic Questionnaire

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Mailing Address: P.O. Box 3297, Springfield, MO 65808-3297 Business (800) 899-6806 Fax (888) 237-1012

Name ____________________ Birthdate ____________ File # ____________

1. Date diabetes diagnosed by a member of the medical profession? ____________
2. Type of treatment? ❑ Insulin ❑ Oral Medication ❑ Diet only

   Type of insulin and/or oral medication: ____________

   Dosage and frequency: ____________
3. Do you follow a diabetic diet? ❑ Yes ❑ No
4. Have you had any fasting blood sugars performed in the past six (6) months? ❑ Yes ❑ No If Yes, results: ____________
5. Results and date of your most recent Hgh A1c (glycosylated hemoglobin), if known: ____________
6. How often do you test your blood for glucose? ____________
7. Since your treatment began, have you ever been treated for a diabetic coma or insulin shock by a member of the medical profession? ❑ Yes ❑ No If Yes, when? ____________
8. Within the last twelve (12) months have you been diagnosed by a member of the medical profession as having skin infections, skin ulcers, or ever had any amputations? ❑ Yes ❑ No

   If Yes, explain: ____________
9. Have you been diagnosed by a member of the medical profession as having any visual problems (other than corrective lenses), heart or circulatory problems, albumin or protein in your urine, loss of consciousness, or numbness or tingling in your feet or legs? ❑ Yes ❑ No

   If Yes, explain: ____________
10. How many days have you lost from work due to diabetes in the last two (2) years? ____________

    If any time off from work was due to diabetes in the past two (2) years, provide details including dates and duration of time off from work: ____________
11. Name, address, and phone number of the doctor or clinic supervising your treatment:

    ____

    Date of last consultation? ____________

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____________________ ____________________

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this diabetic history.

Epilepsy/Seizure Questionnaire

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Name ______________________ Birthdate ______________________ File # ______________________

1. Date diagnosed by a member of the medical profession: ______________________
2. Type of seizure disorder (if known): ❑ absence/petite mal ❑ tonic clonic/grand mal ❑ other: ______________________
3. Has a cause been determined by a member of the medical profession? ______________________
4. Have you had any CT-scans or MRI's of the brain in the past year? ❑ Yes ❑ No

   If Yes, what were the results? ______________________

   Name, address and phone number of the hospital/clinic/physician that would have a copy of this test:

   ____

   ____

   ____

5. Number of seizures or convulsions per year treated by a licensed member of the medical profession: ______________________
6. Date of the last seizure or convulsion treated by a licensed member of the medical profession: ______________________
7. Please list medications currently used for seizures including dosage, and how often taken: ______________________

   ____

8. If no longer on medication, when did you discontinue treatment and was the medication discontinued at the advice of a medical professional? ______________________

   ____

   ____

9. Name, address, and phone number of the doctor who would have the most current and complete information about your condition:

   ____

   ____

   ____

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______________________ ______________________

Proposed Insured's Signature Date

Please use the back of this sheet, if necessary, to report details which will clarify this epilepsy/seizure history.