

NIBS Pre-Screening Questionnaire

Agent Name: _____ Date: _____

Client Name: _____ Gender: _____ Date of Birth: _____

1. Have you used any form of tobacco? Yes No If yes, date last used: _____

Check all that apply: Cigarettes Pipe Cigars Chew Nicotine gum Patches
 Marijuana

2. Have you ever been rated or declined for insurance? Yes No
 If yes, why? _____

3. Height: _____ Weight: _____

4. Have you ever been treated for high blood pressure or cholesterol? Yes No

5. Has any member of your family (parent or sibling) died from coronary artery disease or cancer prior to age 60? Yes No
 If yes, why? _____

6. Have you had any driving violations in the last 5 years? Yes No
 If yes, details: _____

7. Are you currently taking or have you been advised to take any prescription medications? Yes No

Name of Medication	Dates Used	Quantity Taken	Frequency Taken

8. Have you ever been diagnosed with any of the following? Check all that apply and give details in comments section below.

Depression/anxiety Sleep apnea Diabetes Asthma COPD
 Crohn's/Colitis Heart Disease

9. Other comments/concerns: _____

