SYNERGY PhD®
PENSION • PROTECTION • LEGACY

Medical History and Lifestyle Questionnaire

Personal Information

Name			DOB		Sex		
Height		Weight		Place of Birth		SSN/Tax ID	
Employer			Occupation				
Home Address					Apt		
City		State		Zip		How Long?	
Drivers License		State		Issue		Expiration	

Medical History

Has the Proposed Insured ever been diagnosed as having, been treated for or consulted a licensed health care provider for:

A	Heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart?	
B	A blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins?	
C	Cancer, tumors, masses, cysts or other such abnormalities	
D	Diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system?	
E	Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestines?	
F	A disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine?	
G	Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder?	
H	Seizures, a disorder of the brain or spinal cord, or other nervous system abnormality including a mental or nervous disorder?	
I	Depression, anxiety, stress, an eating disorder or any other nervous, mental, or emotional disorder?	
J	Arthritis, muscle disorder, connective tissue disease or other bone or joint disorders?	

Has the Proposed Insured in the past 3 years had but not sought treatment for?		
K	Fainting spells, nervous disorder, headaches, convulsions or paralysis?	
L	Any pain or discomfort in the chest or shortness of breath?	
M	Disorders of the stomach, intestines, or rectum or blood in the urine?	
N	**Is the Proposed Insured currently under treatment, therapy, or medical observation?**	

Please explain any of the questions answered *YES* above.

Medications

Medication Name	Dosage	Reason

Lifestyle and Family

Has the Proposed Insured ever been diagnosed as having, been treated for or consulted a licensed health care provider for:				
A	Has the Proposed Insured used tobacco of any form in the past 24 months?			
	If Yes to above, date of last use		*Type*	
	Are you currently using nicotine gum or patch?			
B	Has the Proposed Insured ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs?			
C	Has the Proposed Insured ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician?			
	*If **YES** is answered to questions B or C, please complete a Drug/Alcohol Questionnaire*			
D	Does the Proposed Insured engage in regular physical exercise other than which occurs during their work?			
	Type of exercise	Times per week	How Long	
E	Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among the Proposed Insured's parents or siblings?			
F	In the past three years, has the Proposed Insured been in a motor vehicle accident, been charged with a moving violation, or had their license restricted or revoked?			
	If Yes, please explain:			
G	Does the Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years?			
	Country	Date	Length of Stay	Reason

Family Mortality

	Age (If Living)	Health	Age (At Death)	Cause
Father				
Mother				
Sibling ○ M ○ F				
Sibling ○ M ○ F				
Sibling ○ M ○ F				

Personal Physician Information

Name _____ Telephone _____

Clinic Name _____

Address _____ Suite/Office _____

City _____ State _____ Zip _____

Date of Last Visit _____

Reason _____

Date of last Completed Physical _____

Additional Physician/Specialists

Name	Date of Last Visit	Reason