American Income Life Insurance Company
P.O. Box 2608 Waco, TX 76797 254-751-8600
www.ailife.com

RESPIRATORY QUESTIONNAIRE

Name ______________________ Application # ______________________

Asthma Allergies Bronchitis Emphysema Pneumonia Other ______________
(Please circle one of the above)

When diagnosed: ______________________

Do you take medication daily? ☐ Yes ☐ No

Or only when you have a problem? ☐ Yes ☐ No

List all medication(s)	Dosage	Frequency
______________	______________	______________
______________	______________	______________
______________	______________	______________

Name and address of treating doctor: ______________________

____

Date of last attack/episode? ______________________

How often do you have problems or attacks? Daily: ________ Weekly: ________ Monthly: ________

Less than Monthly: ________ Seasonal: ________

Have you ever been hospitalized for this? ☐ Yes ☐ No

If YES, how many days were you hospitalized? ________ When? ______________

Have you ever received treatment in an Emergency Room? ☐ Yes ☐ No

If yes, when? ______________________

Name and address of facility: ______________________

____

Have you smoked cigarettes within the last year? ☐ Yes ☐ No

X ______________________ Date ______________
(Proposed Insured's Signature)

AG-2196