

Gastric Bypass Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M F

Tobacco Usage: _____ Face Amount: _____

State: _____ ___Term 10 15 20 30 ___UL

1. When did the proposed insured have gastric bypass surgery? _____
2. What was the proposed insured's weight prior to having surgery? _____
3. How long as the proposed insured maintained their current weight? _____
4. Did the proposed insured received treatment for medical conditions prior to the surgery that no longer require treatment? (e.g., diabetes, hypertension, heart disease) ___Yes ___No

Please provide details including condition, treatment received and when treatment ended:

5. Is the proposed insured taking any medication? ___Yes ___No
If yes, please provide the name, dosage and condition they are taking the medication for:

