



## Gastro/Intestinal Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: M/ F

Tobacco Usage: \_\_\_\_\_

Face Amount: \_\_\_\_\_

State of Residence: \_\_\_\_\_

\_\_\_Term 10 15 20 30      \_\_\_UL

1. What is the actual diagnosis and date of diagnosis? \_\_\_\_\_

2. When did the proposed insured first experience symptoms? \_\_\_\_\_

3. Does the proposed insured experience any of the following? (Check all that apply)

\_\_\_Black stools      \_\_\_Vomiting      \_\_\_Bleeding

4. Has the proposed insured had any weight loss in the last 6 months? \_\_\_Yes \_\_\_No  
(If yes, amount of loss): \_\_\_\_\_

5. Has the proposed insured had any surgery for this condition? \_\_\_Yes \_\_\_No  
(If yes, please provide date and details):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What tests or procedures have been done to diagnose this condition?  
\_\_\_\_\_  
\_\_\_\_\_

7. Is the proposed insured taking any medication for this condition or any other? \_\_\_Yes \_\_\_No  
(If yes, please provide name, dosage, and frequency):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_