

FSG Medical History Quick Quote

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| **Section A – Personal Information** |
| Client Name:       M [ ]  - F [ ]  | Date of Birth:       |
| Advisor Name:       | Height:       |
| Firm:       | Weight:       |
| **Section B – Personal Health History (For “Yes” Answers, please provide details)** |
| **In the last 10 years, have you been treated for, or diagnosed with (Please Circle):** | Yes | No |
| 1 | High blood pressure, heart attack, chest pain, heart murmur, irregular heartbeat, stroke, or any other disease or disorder of the heart or blood vessels?Most recent blood pressure reading       Cholesterol       Ratio       | [ ]  | [ ]  |
| 2 | Cancer, tumor, cyst or growth? Type       Date(s)       Stage/Grade       | [ ]  | [ ]  |
| 3 | Asthma, bronchitis, emphysema, tuberculosis, or any other disease or disorder of the lungs or respiratory system?  | [ ]  | [ ]  |
| 4 | Seizure, paralysis, headaches, multiple sclerosis, or any other disease or disorder of the brain or nervous system?  | [ ]  | [ ]  |
| 5 | Chronic fatigue, stress, depression, anxiety, or any emotional or psychological disorder? | [ ]  | [ ]  |
| 6 | Hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas, or digestive tract?  | [ ]  | [ ]  |
| 7 | Diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? Date of Diagnosis       Current A1C       Treatment       | [ ]  | [ ]  |
| 8 | Kidney stones, nephritis, blood or protein in the urine, HIV, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? | [ ]  | [ ]  |
| 9 | Any disease or disorder of the bones, joints, or muscles? | [ ]  | [ ]  |
| **Section C – Family and Personal History** |
| 10 | Have your parents or siblings died from diabetes, cancer, stroke, or heart disease? Age at death       | [ ]  | [ ]  |
| 11 | Are you **currently** taking any medications? Provide details (Give name of drug, dosage, and reason for taking):       | [ ]  | [ ]  |
| **Section D – Activities and Health Habits** |
| **In the last 5 years…** | Yes | No |
| 12 | Have you used tobacco in any form (including gum/patch)? Type       Date last used       | [ ]  | [ ]  |
| 13 | Engaged in any of the following activities: scuba/skin diving, pilot, organized motor vehicle racing, skydiving, hang gliding, mountain climbing, or rodeo? | [ ]  | [ ]  |
| 14 | Any future foreign travel plans outside the U.S. or Canada? Provide details in space below. | [ ]  | [ ]  |
| 15 | Been in a motor vehicle accident, had a DUI or have more than two moving violations? | [ ]  | [ ]  |
| 16 | If answered **YES** to any question 1-15 above please provide details:      |