

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: | | | |