# DEPRESSION QUESTIONNAIRE

Agent: Phone: Fax:

Proposed Insured Name: ___________________________________ ❐ M ❐ F Date of Birth: ______________________
Face Amount: _____________________ Max. Premium: $__________/year ❐ UL ❐ WL ❐ Term ❐ Survivorship
Do you currently smoke cigarettes? ❐ Y ❐ N If no, did you ever smoke: ❐ Never ❐ Quit (Date): ________________________
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): ❐ Y ❐ N
If Yes, please provide details:_______________________________________________________________________________________
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____________________________________
Height: ____ft. ____in. Weight: ____lbs.

***(1) Date(s) of initial and subsequent episodes of depression:*** _______________________________________________________

***(2) What specific type of depression has been diagnosed?***

- ❐ Bipolar Disorder (mixed)
- ❐ Bipolar Disorder (manic)
- ❐ Bipolar Disorder (depressed)
- ❐ Dysthymia
- ❐ Major Depression
- ❐ Other: _______________________________________________________

***(3) Has the proposed insured been hospitalized for the treatment of depression? If yes, dates:*** ______________________________

***(4) Please advise of the medications used to treat the condition:***

| Name of Medication (Prescription or Otherwise) | Dates used | Quantity Taken | Frequency Taken |
|---|---|---|---|
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***(5) Has the proposed insured been treated with electric shock therapy (ECT)? If yes:***

Date first ECT treatment: ______________ Date most recent ECT treatment: ___________ Total No. of ECT treatments: ____

***(6) Has the proposed insured had (or been diagnosed with) any of the following conditions:***

- ❐ Alcohol abuse? If yes, date of last alcohol use: ________________________________________________________________
- ❐ Drug abuse? If yes, date of last drug use: _____________________________________________________________________
- ❐ Personality Disorder? If yes, give date diagnosed & exact name of the condition: ____________________________________
- ❐ Psychotic Disorder? If yes, give date diagnosed & exact name of the condition: _____________________________________
- ❐ Suicidal thoughts? If yes, date of last such thought: ______________________________________________________________
- ❐ Suicide attempt(s)? If yes, date of last attempt: _________________________________________________________________

***(7) Does the proposed insured have any other medical conditions? If yes, please describe:***

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