

# Drug Use

## Questionnaire



Knowledge. Experience. Results.

**Please answer all questions applicable to the client's medical history.**

Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.  Term  Permanent

Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

Does the client presently use any drugs other than those prescribed by a physician or those available over the counter?

Yes  No If no, date of last drug use \_\_\_\_\_ If yes, complete table below

Type	Usual Quantity	Frequency of Use	How Taken; IV	Dates: From - To

Did the client ever use other drugs or more drugs than they currently use?

Yes  No If yes, complete table below

Type	Usual Quantity	Frequency of Use	How Taken; IV	Dates: From - To

Is the client currently attending N.A. meetings or similar recovery groups?  Yes  No Dates \_\_\_\_\_

Has the client ever been treated for excessive drug use

Yes  No If yes, provide date(s) and details \_\_\_\_\_

Any relapses

Yes  No If yes, provide date(s) and details \_\_\_\_\_

Any legal troubles because of drug use

Yes  No If yes, provide date(s) and details \_\_\_\_\_

Any driving violations

Yes  No If yes, provide date(s) and details \_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

Is the client taking or has the client ever been prescribed Suboxone or any other medication to control his/her drug use? If yes, please provide details:

List any other major health problems the client has:

**Questions? Call Jim or Teresa at 877.564.1707.**

**Please email the completed form to [jrmosel@moseleymcgill.com](mailto:jrmosel@moseleymcgill.com).**

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