

ASTHMA

AGENT NAME: _____

CLIENT NAME: _____ Date: _____

1. Age at onset? _____
2. When was the condition diagnosed? _____
3. What causes the asthma (seasonal asthma, allergy, exercise induced etc.)?
 Seasonal asthma
 Allergies
 Exercise induced
 Other _____
4. How many attacks per year? _____
5. Last attack? _____

6. Please provide treatment details

(Accurate) Name of Medication	Dosage	Reason

7. Do you require medication daily, or just during an attack? _____
8. How long do your attacks typically last? _____
9. Any hospitalizations or Emergency Room visits? No Yes, when and how often? _____
10. Do you have any limitations / restrictions on activity? _____
11. Has any worked been lost due to this condition? Yes No
12. Is a physician following this condition on a regular basis? Yes No

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