

# DRUG USAGE QUESTIONNAIRE

DATE: \_\_\_\_\_ ADVISOR NAME: \_\_\_\_\_  
PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

## CLIENT INFORMATION:

PROPOSED INSURED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

MALE  FEMALE STATE OF SALE: \_\_\_\_\_

TOBACCO USE:  YES  NO  QUIT WHEN \_\_\_\_\_

OTHER COMPANY ACTIONS:  RATED TABLE \_\_\_  POSTPONED  DECLINED

OTHER COMPANY DETAILS: \_\_\_\_\_

1A) ARE YOU NOW USING OR HAVE YOU PREVIOUSLY USED ANY OF THE FOLLOWING DRUGS?

A) OPIUM DERIVATIVES: HEROIN, MORPHINE, DEMEROL, METHADONE, CODEINE, PERCODAN, DILAUDID, OXYCODONE  YES  NO

B) BARBITURATES: AMYTAL, PHENOBARBITAL, SECONAL, NEMBUTAL, PENTOBARBITAL  YES  NO

C) MARIJUANA: HASHISH, CANNABIS  YES  NO

D) AMPHETAMINES: BENZEDRINE, DEXEDRINE, METHEDRINE, PRELUDIN  YES  NO

E) COCAINE  YES  NO

F) HALLUCINOGENS: LSD, DMT, MESCALINE, PEYOTE, PSILOCYBIN, PCP  YES  NO

G) SEDATIVES AND TRANQUILIZERS: LIBRIUM, VALIUM, QUAALUDE, DELMANE, PLACIDYL  YES  NO

1B) WERE ANY OF THESE PRESCRIBED BY A PHYSICIAN?  YES  NO IF YES, WHICH? \_\_\_\_\_

2) IF YOUR ANSWERED YES TO EITHER QUESTION 1A OR 1B, PLEASE PROVIDE THE FOLLOWING DETAILS

TYPE	USUAL QUANTITY	FREQUENCY OF USE	DATE (FROM-TO)
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_____	_____	_____	_____
_____	_____	_____	_____

3) EXCEPT THOSE PRESCRIBED BY A PHYSICIAN, ARE YOU NOW USING OR HAVE YOU USED IN THE PAST ANY OTHER DRUGS NOT LISTED IN NUMBERS 1 OR 2?  YES  NO IF YES, EXPLAIN: \_\_\_\_\_

4) HAVE YOU SOUGHT MEDICAL TREATMENT BECAUSE OF DRUG USE?  YES  NO

IF YES, PLEASE STATE DATES AND NAMES OF DOCTORS AND/OR INSTITUTIONS CONSULTED:

\_\_\_\_\_

5) DO YOU HAVE ANY OTHER MAJOR HEALTH PROBLEMS  YES  NO

IF YES, PLEASE PROVIDE DETAILS: \_\_\_\_\_

\_\_\_\_\_

Please return via email at

***PlusMarketing@pfnins.com***



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