

KIDNEY TRANSPLANTS QUESTIONNAIRE

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE NO YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. PLEASE NOTE DISORDER THAT MADE THE KIDNEY TRANSPLANT NECESSARY:

- KIDNEY FAILURE DUE TO DIABETES
 KIDNEY FAILURE DUE TO GLOMERULONEPHRITIS
 KIDNEY FAILURE DUE TO POLYCYSTIC KIDNEY DISEASE
 OTHER, PLEASE DETAIL _____

2. DATE OF THE TRANSPLANT _____

3. SOURCE OF THE TRANSPLANT KIDNEY:

- IDENTICAL TWIN
 RELATED DONOR WITH IDENTICAL HLA MATCH
 RELATED DONOR WITHOUT IDENTICAL HLA MATCH
 NON-RELATED LIVE DONOR
 NON-RELATED CADAVER KIDNEY

4. ARE THERE ANY CURRENT SYMPTOMS/COMPLICATIONS?

- NO YES, DETAILS _____

5. GIVE RESULTS OF MOST RECENT KIDNEY FUNCTION TESTS:

BUN _____

SETUM CREATINE _____

URINALYSIS _____

6. PLEASE NOTE ANY OF THE FOLLOWING THAT HAVE OCCURRED (CHECK ALL THAT APPLY):

- FREQUENT INFECTION
 REJECTION EPISODES
 HIGH BLOOD PRESSURE
 CARDIOVASCULAR DISEASE
 TOXICITY FROM TREATMENT
 CANCER
 DISEASE RECURRENCE

7. PLEASE DETAIL ANY CURRENT TREATMENT PRESCRIBED:

8. DATE OF THE LAST TIME A PHYSICIAN WAS CONSULTED TO FOLLOW UP ON THE TRANSPLANT:

9. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY): _____