

## **SARCOIDOSIS 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 \_\_\_\_\_

- |   |  |
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| <p>1. PLEASE LIST DATE OF FIRST DIAGNOSIS _____</p> <p>2. WAS A BIOPSY DONE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. PLEASE LIST STAGE DIAGNOSED _____</p> <p>4. HOW WAS THE SARCOID TREATED?</p> <p><input type="checkbox"/> PREDNISONE<br/><input type="checkbox"/> NO TREATMENT<br/><input type="checkbox"/> OTHER _____</p> <p>DATE TREATMENT COMPLETED _____</p> <p>5. IS THE CLIENT ON MEDICATIONS FOR THIS IMPAIRMENT?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES, DETAILS _____</p> <p>6. PLEASE NOTE WHICH ORGANS WERE INVOLVED (CHECK ALL THAT APPLY):</p> <p><input type="checkbox"/> LUNG<br/><input type="checkbox"/> HEART<br/><input type="checkbox"/> LIVER<br/><input type="checkbox"/> SPLEEN</p> | <p><input type="checkbox"/> EYES</p> <p><input type="checkbox"/> KIDNEY<br/><input type="checkbox"/> CENTRAL NERVOUS SYSTEM<br/><input type="checkbox"/> SKIN<br/><input type="checkbox"/> LYMPHNODES</p> <p>7. PLEASE GIVE RESULTS OF THE MOST RECENT PULMONARY FUNCTION TEST:</p> <p>FVC _____ FEV1 _____</p> <p>8. HAS THERE BEEN ANY EVIDENCE OF RECURRENCE OR PROGRESSION?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES, DETAILS _____</p> <p>8. LIST ANY OTHER ILLNESSES OR IMPAIREMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY): _____</p> |
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Information gathered will be used in the evaluation of the applicant's insurability. Offers are tentative subject to verification of the submitted medical evidence and other criteria used in the underwriting of life insurance.