

## ARTHRITIS QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

(1) *Date of Diagnosis:* \_\_\_\_\_

(2) *What type of arthritis has been diagnosed:* \_\_\_\_\_

(3) *Which tissues have been involved:*

Joints only - which: \_\_\_\_\_  Heart  Lungs  Central Nervous System

Other: \_\_\_\_\_

(4) *Has the condition ever completely disappeared?*  No  Yes If Yes, when did it disappear? \_\_\_\_\_

(5) *If the condition has ever disappeared, has it relapsed?*  No  Yes If it has relapsed, please give some idea of regarding the dates the condition has disappeared and reappeared. Are there any known variables that trigger the onset of the condition or can lead to remission (such as a change in climate, location etc.):

\_\_\_\_\_

\_\_\_\_\_

(6) *Please list any other medical information that may help provide a more realistic preliminary assessment:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(7) *What medications were/are being used to control the arthritic condition or any other condition affecting the proposed insured?*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

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