

SARCROIDOSIS 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. cigars, pipe, snuff, nicotine patch, 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 initial diagnosis:* _____ *How was the sarcoidosis diagnosed (e.g. by x-ray)?* _____

(2) *Was the condition staged? If yes, please check the appropriate stage:* Stage I Stage II Stage III

(3) *Describe current symptoms, if any:* _____

(4) *Was there (is there) any treatment for the condition? If yes, describe:* _____

Date of last treatment: _____

(5) *Has there been any organ involvement?* No Yes; please check *all* that were (are) affected:

Lung Lymph Nodes Kidney Eyes Heart Liver Central Nervous System

Other: _____

(6) *Has there ever been a recurrence?* No Yes; list approximate dates of any recurrent episodes:

(7) *Please provide the results of the most recent pulmonary function tests, if available:* FVC _____ FEV1 _____

(8) *Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:*

(9) *Does the proposed insured take any medications or have any been taken in the past to treat the sarcoidosis? If yes, please list:*

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

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