Celiac Disease Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. When was the proposed insured diagnosed with Celiac Disease? _____

2. Does the proposed insured experience any of the following symptoms: (Check all the apply)

___ Abdominal cramping
___ Chronic diarrhea and/or constipation
___ Steatorrhea
___ Anemia
___ Weight Loss
___ Depression
___ Dermatitis Herpetiformis
___ Intestinal gas, distention and bloating
___ Dental enamel defects
___ Osetopenia or osteoporosis
___ Fatigue
___ Infertility
___ Aphthous ulcers

3. Is the proposed insured disabled as a result of these conditions? ___Yes ___No

4. Is the proposed insured taking any medication? ___Yes ___No
(If yes, please provide the name, dosage and frequency): _____
_____
_____

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