Acromegaly 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 Acromegaly?

2. Does the proposed insured experience any of the following symptoms? (Check all that apply)
___Joint pain ___Enlarged heart ___Arthritis ___Enlargement of other organs ___Fatigue
___Headaches ___Loss of vision ___ Weakness in arms/legs

3. What treatment has the proposed insured received for this condition:
_____
_____

a. Surgery Details: _____
_____

b. Radiation Therapy Details: _____ _____
_____

c. Injection of a growth hormone blocking drug Details: _____
_____

4. Please provide name, dosage and frequency of all medications:
_____
_____
_____
_____
_____

5. Does the proposed insured have any other health conditions for which they receive ongoing treatment? (If yes, please provide details)
_____
_____
_____
_____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787