Addison 's disease Questionnaire

Name: _________________________ Date of Birth: ________________________

Height: ________ Weight: ________ Sex: M/F

Tobacco Usage: ________________ Face Amount: _______________________

State of Residence: ____________________

___Term 10 15 20 30 __UL

1. When was the proposed insured diagnosed? ____

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

___Fatigue
___Weight loss
___Loss of appetite
___Nausea
___ Vomiting
___ Diarrhea
___ Lightheadedness or fainting
___ Depression
___ Difficulty concentrating
___Hyperpigmentation
___ Shakiness
___Low blood sugar

3. Is the proposed insured currently receiving, or has received in the past, any of the following treatments? (Check all that apply)

___Hormone replacement (cortisol and/or aldosterone)
___Increased salt intake
___Other Details: ____

4. Is the proposed insured taking medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency): ___________________________________

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