Ankylosing Spondylitis 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 first diagnosed with Ankylosing Spondylitis?

_____

2. Does the proposed insured suffer from any of the following? (Check all that apply)
___Pain, stiffness, limited motion in back, hips, or neck
___Fatigue
___Inflammation of the Iris

3. How has the proposed insured been treated? (Check all that apply)
___Exercise
___Medication
___Physical Therapy
___Assistive Devices such as canes or walkers

4. Is, the proposed insured, disabled as a result of this condition? ___Yes ___No
(If yes, please provide the date of disability and annual disability income):

_____
_____
_____

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

_____
_____
_____
_____

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