Primary Sclerosing Cholangitis Questionnaire

Name: ________________________ Date of Birth: ________________________

Height: ________ Weight: ________ Sex: M/F

Tobacco Usage: _______________ Face Amount: _______________________

___Term 10 15 20 30 ___UL

1. What date was the proposed insured diagnosed with this condition: __________________________

2. Which of the following symptoms had the proposed insured had in relation to this condition?
___ Fatigue ___Itching ___Jaundice ___Dark Urine ___abdominal pain
___Nausea ___Enlarged Liver ___Ulcerative Colitis

3. How is this condition being treated?
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____
____

4. Is the proposed insured disabled as a result of this condition? ___Yes ___No

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