Chronic Fatigue Syndrome 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 with CFS? ______________________________________

2. Does the proposed insured experience any of the following? (Check all that apply)
___Forgetfulness, memory loss, confusion, difficulty in concentrating
___Sore throat
___Tender lymph nodes in the neck or armpits.
___Muscle pain
___Joint pain
___New headaches
___Unrefreshed sleep
___Fatigue that lasts more than 24 hours

3. Has the proposed insured received/currently receiving any of the following treatments?
___Medication Date: _________________________
___Exercise Program Date: _________________________
___Cognitive behavioral therapy Date: _________________________

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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