Grave's Disease 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 Grave's Disease?

_____

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

___Weight loss despite increased appetite ___Increased sensitivity to heat
___Excessive perspiration ___Faster heart rate, higher blood pressure
___Bulging eyes ___More frequent bowel movements
___Muscle weakness, trembling hands ___Development of a goiter
___In women, change in frequency or total cessation of menstrual periods

3. Has the proposed insured been diagnosed with any of the following conditions?

___Atrial fibrillation ___Heart failure ___Graves' ophthalmopathy

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

_____
_____
_____

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

_____
_____
_____
_____

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