Huntington's Chorea 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 Huntington's Chorea?
_____

2. Does the proposed insured suffer from any of the following symptoms: (Check all that apply)
___Involuntary movements or rigidity ___Weight loss ___Dementia ___Seizures
___Changes in mental status (irritability, moodiness, depression, antisocial behavior)

3. Has the proposed insured ever been hospitalized for this condition? ___Yes ___No
(If yes, please provided dates and details): _____
_____
_____

4. Has the proposed insured ever been disabled as a result of this condition? ___Yes ___No
(If yes, please provided dates and details): _____
_____
_____

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

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