



Muscular Dystrophy 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 muscular dystrophy?

2. What form of muscular dystrophy has the proposed insured been diagnosed with?

___Myotonic ___Duchenne ___Becker ___Limb-girdle
___congenital ___Distal ___Emery-Dreifuss ___Facioscapulohumeral
___Oculopharyngeal

3. Which of the following symptoms does the proposed insured experience?

___ Muscle weakness ___ Muscle spasms or stiffening after use
___ Hand weakness ___ Foot drop
___ Clumsiness ___ Frequent falling
___ Difficulty getting up ___ Waddling Gait ___ Curvature of the spine

4. Is, the proposed insured, disabled as a result of this condition? ___ Yes ___ No

(If yes, provide details) _____

5. Is the proposed insured taking any medication for this condition or any other? ___ Yes ___ No

(If yes, please provide name, frequency, and dosage)
