Myasthenia Gravis Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. Which form of Myasthenia Gravis has the proposed insured been diagnosed with?
___Generalized myasthenia gravis ____Ocular myasthenia gravis
___Transitory Neonatal Myasthenia Gravis ____Congenital Myasthenia Gravis
___Familial Infantile (Congenital) Myasthenia Gravis

2. What is the date of diagnosis? _____

3. Which of the following symptoms does the proposed insured have? (Check all that apply)
___Weakness and drooping of the eyelids (ptosis) ___weakness of eye muscles
___Excessive muscle fatigue following activity ___weakness of facial muscles
___Impaired articulation of speech (dysarthria) ___Difficulties chewing and swallowing
___Weakness of the upper arms and legs

4. Is, the proposed insured, disabled as a result of this condition? _____Yes _____No
(If yes, provide details) _____
_____
_____

5. Does the proposed insured take any medication? _____Yes _____No
(If yes, please list the name, dosage, and frequency)
_____
_____
_____
_____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787