Osler-Weber-Rendu Disease 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 Osler-Weber-Rendu Disease?

_____

2. What part of the body has the proposed insured had a Telangiectasia or AVM?

___Nose ___Skin ___GI tract ___Brain ___Liver ___Lungs ___Other

Details: _____

3. Has the proposed insured had any of the following treatments?

___Septal dermoplasty Date: _____
___Embolization Date: _____
___Laser Therapy Date: _____
___Iron replacement Date: _____
___Transfusions Date: _____
___Other Date: _____

Details: _____

_____

_____

_____

4. 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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