Rheumatoid Arthritis Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. Please provide the date of diagnosis: _____

2. Does the proposed insured experience any of the following?
(Check all that apply):
___Pain, stiffness swelling in joints ___Depression ___Fatigue

3. What tissues have been involved?
(Check all that apply):
___Joints only ___Heart ___Lungs ___Central Nervous System

4. Have the symptoms ever complete disappeared? ____Yes ____No
(If yes, did they reappear)? _____Yes _____No
(If yes, when)_____

5. How is the proposed insured being treated?

___ Anti-inflammatory drugs	Date: _____
___Topical Pain Relievers	Date: _____
___Corticosteroids	Date: _____
___Narcotic pain relievers	Date: _____
___Methotrexate, Imuran or Cytoxan	Date: _____
___Remicaid, Arava, Enbrel, Humira	Date: _____
___Apheresis	Date: _____

6. Is the proposed insured disabled as a result of this condition? ___Yes ___No

7. Is the proposed insured currently 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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