Shingles Questionnaire

Name: _____ Date of Birth: _____

Height: _____Weight: _____ Sex: M/F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 ___UL

1. When was shingles first diagnosed? _____

2. Does the proposed insured suffer any of the following symptoms: (Check all that apply)
___ Headache ___Sensitivity to light ___Flu-like symptoms
___Post herpetic Neuralgia ___Cranial nerve complications ___ Herpes zoster ophthalmic us

3. Is the proposed insured now, or have they in the past received any of the following treatments:
___Antiviral Medication Date(s): _____
___Corticosteroids Date(s): _____
___Topical Antibiotics Date(s): _____
___Antidepressant medication Date(s): _____
___Anticonvulsants medication Date(s): _____
___ Opiods (such as codeine) Date(s) _____

4. Is the proposed insured currently taking any medication for this condition, or any other?
_____Yes _____No
(If yes, please provide name, dosage, and frequency)
_____
_____
_____
_____
_____

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