Grave's Disease Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with Grave's Disease? _____

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

___ Weight loss despite increased appetite
___ Faster heart rate, higher blood pressure
___ More frequent bowel movements
___ Development of a goiter
___ Excessive perspiration
___ Increased sensitivity to heat
___ Muscle weakness, trembling hands
___ Bulging eyes
___ In women, change if frequency or total cessation of menstrual periods
___ Other: _____

3. Has the proposed insured been diagnosed with any of the following conditions

___ Atrial fibrillation ___ Heart failure ___ Grave's ophthalmopathy

4. Is the proposed insured being treated for any other health conditions? ___ Yes ___ No

5. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
If yes, provide name, dosage and frequency of medication(s) _____
_____
_____

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