Glomerulonephritis Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M/ F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. When was the proposed insured diagnosed with Glomerulonephritis? _____

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

___ Unintentional weight loss
___ Fatigue
___ Generalized itching
___ Easy bruising or bleeding
___ Muscle twitching
___ Hyperpigmentation
___ Nosebleed
___ Blood in the vomit or in stools
___ Nausea, vomiting
___ Headache
___ Decreased urine output
___ Decreased alertness
___ Muscle cramps
___ High blood pressure
___ Decreased sensation in the hands, feet, or other areas
___ General ill feeling
___ Frequent hiccups
___ Need to urinate at night
___ Confusion, delirium
___ Seizures

3. Has the proposed insured ever received or been recommended to receive any of the following treatments?

___ Dialysis - Details: _____
___ Diet Restrictions - Details: _____
___ Other - Details: _____

4. Is the proposed insured taking any medication? ___Yes ___No
(If yes, please provide the name, dosage, and frequency): _____
_____
_____

5. When did the client last have a kidney function test? _____
(Please provide results if possible): _____
_____

6. Is the proposed insured disabled as a result of this condition? ___Yes ___No
(If yes, please provide details): _____
_____
_____