Osteoporosis 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 Osteoporosis? _____
2. Has the proposed insured had a Bone Density Test (BMD Test)? ___Yes ___No
   (If yes, please provide the following):
   Date: _____
   T-Scores: _____
3. Has the proposed insured ever experienced any of the following?
   ___ Fractures Date: _____
   Details: _____
   ___ Spinal Compression Fractures Date: _____
   Details: _____
   ___ Low back and/or neck pain 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):
   _____
   _____
   _____