Vasculitis 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? _____

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

___ Fever ___ Fatigue ___ Weight Loss
___ Muscle/joint pain ___ Loss of appetite ___ Numbness/Weakness
___ Skin lesions ___ Vision problems ___ Skin Rash

3. What type of Vasculitis has the proposed insured been diagnosed with? (Check all that apply)

___ Bahcet's Syndrome ___ Buergre's Disease ___ Churg-Strauss Syndrome
___ Cryoglobulinemia ___ Giant cell arteritis ___ Henoch-Schonlein purpura
___ Hypersensitivity Vasculitis ___ Kawasaki Disease ___ Microscopic polyangiitis
___ Polyarteritis nodosa ___ Polymyalgia rheumatica ___ Rheumatoid vasculitis
___ Takayasu's arteritis ___ Wegener's granulomatosis

4. Does the proposed insured experience any of the following: (Check all that apply)

___ Fever ___ Fatigue ___ Weight Loss ___ Muscle/joint pain
___ Loss of appetite ___ Numbness/Weakness ___ Skin lesions
___ Vision problems ___ Skin Rash

5. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency):

Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____
Name: _____ Dosage: _____ Frequency: _____

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