



Berger's Disease Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/ F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___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)
___Blood in the Urine ___Hypertension ___Protein in the urine ___Groin Pain

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

___Dialysis Details: _____

___Kidney Transplant Details: _____

___Other Details: _____

4. When did the client last have a kidney function test? _____

Please provide results if possible: _____

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): _____
