Psoriatic Arthritis Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M F

Tobacco Usage: _____ Face Amount: _____

___Term 10 15 20 30 __UL

1. Please provide the date of diagnosis: _____

2. Which type of psoriatic arthritis has the proposed insured been diagnosed with?

___Symmetric arthritis ___Asymmetric arthritis ___Distal interphalangeal predominant
___Spondylitis ___Arthritis mutilans

3. Does the proposed insured experience any of the following? (Check all that apply):
___Pain, stiffness swelling in joints
___Irritation and redness of the eye
___Red, scaly patches of the skin

4. How is the proposed insured being treated?

___ Anti-inflammatory drugs	Date: _____
___Disease-modifying ant rheumatic drugs	Date: _____
___(Methotrexate, Neoral, Sandimmune)	Date: _____
___Steroids	Date: _____
___Biologic therapy (Enbrel)	Date: _____
___Physical Therapy	Date: _____
___Assistive devices	Date: _____
___Other_____	Date: _____

5. Is the proposed insured disabled as a result of this condition? _____Yes _____No

6. Is the proposed insured taking any medications? ____Yes ____No
(If yes, please provide the name, dosage, and frequency of all medications)
_____
_____
_____
_____

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