

# Ankylosing Spondylitis Questionnaire

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:     Male / Female      
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ State: \_\_\_\_\_ Smoker:     Y / N     Face Amount: \_\_\_\_\_  
Type of Insurance:     Universal Life     Whole Life     Survivorship     Term (# of years    )

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1. When was the proposed insured first diagnosed with Ankylosing Spondylitis? \_\_\_\_\_

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

Pain, stiffness, limited motion in back, hips or neck       Fatigue  
 Inflammation of the iris       Other: \_\_\_\_\_

3. Is the proposed insured been disabled as a result of this condition?  Yes  No  
If yes, provide dates and monthly disability income: \_\_\_\_\_  
\_\_\_\_\_

4. How has the proposed insured been treated for this condition?

Exercise  
 Medication      Name, dosage and frequency: \_\_\_\_\_  
 Physical Therapy      Provide frequency: \_\_\_\_\_  
 Assistive Devices; such as canes or walkers  
 Other: \_\_\_\_\_

5. Is the proposed insured current taking any medication(s)?  Yes  No  
If yes, provide name, dosage and frequency of medication(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_