

# Cushing's Disease 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 \_\_\_\_\_)

---

1. When was the proposed insured first diagnosed with Cushing's Disease? \_\_\_\_\_

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

- |                                             |                                            |                                                        |
|---------------------------------------------|--------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Upper body obesity | <input type="checkbox"/> Rounded face      | <input type="checkbox"/> Increased fat around the neck |
| <input type="checkbox"/> Thinning arms/legs | <input type="checkbox"/> Fragile/thin skin | <input type="checkbox"/> Bruises easily                |
| <input type="checkbox"/> Other: _____       |                                            |                                                        |

3. Has the proposed insured ever had a rib and/or spinal column fracture?  Yes  No  
If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

4. What treatments has the proposed insured received for this condition?

<input type="checkbox"/> Surgery	Details: _____
<input type="checkbox"/> Medication	Details: _____
<input type="checkbox"/> Other: _____	

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