

# Hypopituitarism 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 hypopituitarism? \_\_\_\_\_

2. What is the cause?

- |   |   |
|---|---|
| <input type="checkbox"/> Pituitary tumor    | <input type="checkbox"/> Inadequate blood supply to pituitary gland |
| <input type="checkbox"/> Infection          | <input type="checkbox"/> Inflammatory disease                       |
| <input type="checkbox"/> Sarcoidosis        | <input type="checkbox"/> Amyloidosis                                |
| <input type="checkbox"/> Radiation therapy  | <input type="checkbox"/> Surgical removal of pituitary tissue       |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Tumors of the hypothalamus                 |
| <input type="checkbox"/> Head injury        | <input type="checkbox"/> Other: _____                               |

3. What symptoms does the proposed insured experience? (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Loss of male/female characteristics    | <input type="checkbox"/> Stunted growth      |
| <input type="checkbox"/> Dwarfism                               | <input type="checkbox"/> Underactive thyroid |
| <input type="checkbox"/> Insufficient corticotrophic production | <input type="checkbox"/> Other: _____        |

4. How is the proposed insured being treated for this condition? \_\_\_\_\_  
\_\_\_\_\_

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

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