

# Muscular Dystrophy 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 Muscular Dystrophy? \_\_\_\_\_

2. What was the diagnosis?

Myotonic       Duchenne       Becker       Limb-girdle       Congenital  
 Distal       Emery-Dreifuss       Facioscapulohumeral       Oculopharyngeal

3. Which of the following symptoms does the proposed insured experience? (Check all that apply.)

Muscle weakness       Muscle spasms or stiffening after use  
 Hand weakness       Foot drop  
 Clumsiness       Frequent falling  
 Difficulty getting up       Waddling gait  
 Curvature of the spine       Other: \_\_\_\_\_

4. Is the proposed insured disabled as a result of this condition?  Yes  No

If yes, provide details: \_\_\_\_\_  
\_\_\_\_\_

5. Is the proposed insured current taking any medication(s)?  Yes  No

If yes, provide name, dosage and frequency of medication(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_