

Sarcoidosis 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? _____

2. What stage of sarcoidosis has been diagnosed? Stage 1 Stage 2 Stage 3

3. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

- | | | | |
|-------------------------------------|--|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of appetite or weight | <input type="checkbox"/> Fever | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Enlarged lymph nodes | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Joint stiffness or swelling | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Irregular heartbeat |

4. What organ systems are involved?

- | | | | | |
|--------------------------------|--|--------------------------------|--|---|
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Eyes | <input type="checkbox"/> Skin | <input type="checkbox"/> Lymph Nodes | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Kidneys/Urinary Tract | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Nervous System |

5. Has the proposed insured received any of the following treatments?

- | | |
|---------------------------------------|-------------|
| <input type="checkbox"/> Prednisone | Date: _____ |
| <input type="checkbox"/> Plaquenil | Date: _____ |
| <input type="checkbox"/> Methotrexate | Date: _____ |
| <input type="checkbox"/> Imuran | Date: _____ |
| <input type="checkbox"/> Cytoxan | Date: _____ |
| <input type="checkbox"/> Other: _____ | |

6. 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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