Addison's Disease Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with Addison's Disease? _____

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

___ Fatigue	___ Weight loss	___ Loss of appetite
___ Nausea	___ Vomiting	___ Diarrhea
___ Hyperpigmentation	___ Lightheadedness or fainting	___ Shakiness
___ Low blood sugar	___ Difficulty concentrating	___ Depression

___ Other: _____
_____

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

___ Hormone replacement (cortisol and/or aldosterone)
___ Increased salt intake
___ Other: _____

4. 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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