

## SARCROIDOSIS QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$\_\_\_\_\_/year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_

(1) *Date of initial diagnosis:* \_\_\_\_\_ *How was the sarcoidosis diagnosed (e.g. by x-ray)?* \_\_\_\_\_

(2) *Was the condition staged? If yes, please check the appropriate stage:*  Stage I  Stage II  Stage III

(3) *Describe current symptoms, if any:* \_\_\_\_\_  
 \_\_\_\_\_

(4) *Was there (is there) any treatment for the condition? If yes, describe:* \_\_\_\_\_

*Date of last treatment:* \_\_\_\_\_

(5) *Has there been any organ involvement?*  No  Yes; please check *all* that were (are) affected:

- Lung  Lymph Nodes  Kidney  Eyes  Heart  Liver  Central Nervous System  
 Other: \_\_\_\_\_

(6) *Has there ever been a recurrence?*  No  Yes; list approximate dates of any recurrent episodes:  
 \_\_\_\_\_

(7) *Please provide the results of the most recent pulmonary function tests, if available:* FVC \_\_\_\_\_ FEV1 \_\_\_\_\_

(8) *Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(9) *Does the proposed insured take any medications or have any been taken in the past to treat the sarcoidosis? If yes, please list:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken