

## KIDNEY DISEASE—RENAL INSUFFICIENCY QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

*Note: In order to assess the possibility of obtaining life insurance with the presence of kidney disease, it is helpful to obtain results to many of the test related questions below. A quick call by the proposed insured to their health care provider may indicate many of the test results requested. Alternatively, perhaps the health care provider may be willing to fax the latest lab findings, avoiding the delays of waiting for a formal APS. If this initial investigation indicates only minor abnormalities, and offers of insurance are likely, a full APS, as well as current lab studies, will be requested by the insurance company during the formal application process.*

(1) Please provide date of first diagnosis with kidney disease: \_\_\_\_\_

(2) Please indicate the specific name of the kidney disorder diagnosed by your physician: \_\_\_\_\_

(3) Please provide approximate dates and readings of known blood pressure measurements:

Approximate date(s):	Systolic/Diastolic reading(s):	Approximate date(s):	Systolic/Diastolic reading(s):

(4) Please advise of the following laboratory findings, if previously (and recently) done by your physician?

Laboratory findings of:	Date of most recent test:	Level of findings:	Normal reference range:
Protein in the urine (proteinuria):			
Blood in the urine (hematuria):			
Blood urea nitrogen (BUN) level:			
Creatinine level:			

(5) Does the proposed insured take any medications? If yes, please list:

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

(6) Is there any known family history relating to kidney/cardiovascular disease? If yes, please describe:

	Age (if living)	Age (at death)	Cause of death, if deceased:	History of kidney disease?	History of heart disease or circulatory disorder?	History of stroke?
<i>Mother</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Father</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Sister(s)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Brother</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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