



## Addison 's disease Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: M/F

Tobacco Usage: \_\_\_\_\_

Face Amount: \_\_\_\_\_

State of Residence: \_\_\_\_\_

\_\_\_Term 10 15 20 30      \_\_\_UL

1. When was the proposed insured diagnosed? \_\_\_\_\_

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

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Loss of appetite         |
| <input type="checkbox"/> Nausea                      | <input type="checkbox"/> Vomiting    | <input type="checkbox"/> Diarrhea                 |
| <input type="checkbox"/> Lightheadedness or fainting | <input type="checkbox"/> Depression  | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Hyperpigmentation           | <input type="checkbox"/> Shakiness   | <input type="checkbox"/> Low blood sugar          |

3. Is the proposed insured currently receiving, or has received in the past, any of the following treatments? (Check all that apply)

- Hormone replacement (cortisol and/or aldosterone)  
 Increased salt intake  
 Other Details: \_\_\_\_\_

4. Is the proposed insured taking medication for this condition or any other? \_\_\_Yes \_\_\_No  
(If yes, please provide the name, dosage, and frequency): \_\_\_\_\_

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