



Chronic Fatigue Syndrome 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 with CFS? _____

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

___ Forgetfulness, memory loss, confusion, difficulty in concentrating

___ Sore throat

___ Tender lymph nodes in the neck or armpits.

___ Muscle pain

___ Joint pain

___ New headaches

___ Unrefreshed sleep

___ Fatigue that lasts more than 24 hours

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

___ Medication Date: _____

___ Exercise Program Date: _____

___ Cognitive behavioral therapy Date: _____

4. Is the proposed insured disabled as a result of this condition? ___ Yes ___ No

5. Is the proposed insured taking any medication? ___ Yes ___ No

(If yes, please provide the name, dosage, and frequency): _____
