



Guillain-Barré Syndrome Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/ F

Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30

___UL

1. When was the proposed insured diagnosed with Guillain-Barré Syndrome?

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

___Numbness or tingling in hands or feet ___Numbness or tingling around mouth/lips
___Muscle weakness ___Loss of reflexes ___Difficulty speaking, chewing, swallowing
___Inability to move eyes ___Back pain

3. Has the proposed insured ever received immunotherapy treatment for this condition? ___Yes ___No
(If yes, please provide dates/details of treatment): _____

4. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide name, dosage, and frequency): _____
