# Huntington's Chorea Questionnaire

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: M F

Tobacco Usage: _____ Face Amount: _____

State: ___ ___Term 10 15 20 30 ___UL

1. When was the proposed insured diagnosed with Huntington's Chorea?
   _____

2. Does the proposed insured suffer from any of the following symptoms: (Check all that apply_
   ___Involuntary movements or rigidity ___Changes in mental status (irritability, moodiness depression, antisocial behavior)
   ___Weight loss ___Dementia
   ___Seizures ___

3. Has the proposed insured ever been hospitalized for this condition? ___Yes ___No
   If yes, please provided dates and details:
   _____
   _____
   _____

4. Has the proposed insured ever been disabled as a result of this condition? ? ___Yes ___No
   If yes, please provided dates and details:
   _____
   _____
   _____

5. Is the proposed insured taking any medication for this condition or any other?
   ___Yes ___No
   If yes, please provide the name, dosage and frequency of all medications: _____
   _____
   _____
   _____