

**Hypopituitarism 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 Hypopituitarism?

\_\_\_\_\_

2. What is the cause of Hypopituitarism?

- |   |   |
|---|---|
| <input type="checkbox"/> Pituitary tumor    | <input type="checkbox"/> inadequate blood supply to pituitary gland |
| <input type="checkbox"/> Infection          | <input type="checkbox"/> Inflammatory Disease                       |
| <input type="checkbox"/> Sarcoidosis        | <input type="checkbox"/> Amyloidosis                                |
| <input type="checkbox"/> Radiation Therapy  | <input type="checkbox"/> Surgical removal of pituitary tissue       |
| <input type="checkbox"/> autoimmune disease | <input type="checkbox"/> tumors of the hypothalamus                 |
| <input type="checkbox"/> head injury        |   |

3. What symptoms does the proposed insured experience?

- |   |  |
|---|--|
| <input type="checkbox"/> Loss of male/female characteristics    | <input type="checkbox"/> stunted growth      |
| <input type="checkbox"/> dwarfism                               | <input type="checkbox"/> underactive thyroid |
| <input type="checkbox"/> insufficient corticotrophic production |  |

4. How is the proposed insured been treated for this condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Is the proposed insured currently taking any medication for this condition or any other?  Yes  No If yes, please provide names, dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_