

Muscular Dystrophy 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 muscular dystrophy?

2. What form of muscular dystrophy has the proposed insured been diagnosed with?

____Myotonic

____Duchenne

____Becker

____Limb-girdle

____congenital

____Distal

____Emery-Dreifuss

____Facioscapulohumeral

____Oculopharyngeal

3. Which of the following symptoms does the proposed insured experience?

____ Muscle weakness

____ Muscle spasms or stiffening after use

____ Hand weakness

____ Foot drop

____ Clumsiness

____ Frequent falling

____ Difficulty getting up

____ Waddling Gait

____ Curvature of the spine

4. Is the proposed insured taking any medication for this condition or any other? ____Yes ____No
If yes, please provide name, frequency and dosage.

5. Is the proposed insured disabled as a result of this condition? ____Yes ____No