



Myasthenia Gravis Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

____Term 10 15 20 30

____UL

1. Which form of Myasthenia Gravis has the proposed insured been diagnosed with?

___ Generalized myasthenia gravis

___ Ocular myasthenia gravis

___ Transitory Neonatal Myasthenia Gravis

___ Congenital Myasthenia Gravis

___ Familial Infantile (Congenital) Myasthenia Gravis

2. What is the date of diagnosis? _____

3. Which of the following symptoms does the proposed insured have? (Check all that apply)

___ Weakness and drooping of the eyelids (ptosis)

___ weakness of eye muscles

___ Excessive muscle fatigue following activity

___ weakness of facial muscles

___ Impaired articulation of speech (dysarthria)

___ Difficulties chewing and swallowing

___ Weakness of the upper arms and legs

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

(If yes, provide details) _____

5. Does the proposed insured take any medication? ____ Yes ____ No

(If yes, please list the name, dosage, and frequency)

