



Osler-Weber-Rendu Disease Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

State of Residence: _____

___Term 10 15 20 30

___UL

1. When was the proposed insured diagnosed with Osler-Weber-Rendu Disease?

2. What part of the body has the proposed insured had a Telangiectasia or AVM?

___Nose

___Skin

___GI tract

___Brain

___Liver

___Lungs

___Other

Details: _____

3. Has the proposed insured had any of the following treatments?

___Septal dermoplasty

Date: _____

___Embolization

Date: _____

___Laser Therapy

Date: _____

___Iron replacement

Date: _____

___Transfusions

Date: _____

___Other

Date: _____

Details: _____

4. 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):
