



Pernicious Anemia 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 Pernicious Anemia Disease?

2. Does the proposed insured suffer from any of the following symptoms: (Check all that apply)

- | | | | |
|-----------------------------------------------------------|----------------------------------------------|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pallor | <input type="checkbox"/> Unsteady gait | <input type="checkbox"/> Tongue problems | <input type="checkbox"/> Impaired smell |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Personality changes | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Tingling/numbness of extremities | | | |

3. 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):

