



Psoriatic Arthritis Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M F

Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30

___UL

1. Please provide the date of diagnosis: _____

2. Which type of psoriatic arthritis has the proposed insured been diagnosed with?

___ Symmetric arthritis

___ Asymmetric arthritis

___ Distal interphalangeal predominant

___ Spondylitis

___ Arthritis mutilans

3. Does the proposed insured experience any of the following? (Check all that apply):

___ Pain, stiffness swelling in joints

___ Irritation and redness of the eye

___ Red, scaly patches of the skin

4. How is the proposed insured being treated?

___ Anti-inflammatory drugs

Date: _____

___ Disease-modifying ant rheumatic drugs

Date: _____

___ (Methotrexate, Neoral, Sandimmune)

Date: _____

___ Steroids

Date: _____

___ Biologic therapy (Enbrel)

Date: _____

___ Physical Therapy

Date: _____

___ Assistive devices

Date: _____

___ Other _____

Date: _____

5. Is the proposed insured disabled as a result of this condition? _____ Yes _____ No

6. Is the proposed insured taking any medications? _____ Yes _____ No

(If yes, please provide the name, dosage, and frequency of all medications)

