



## Scleroderma Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: M F

Tobacco Usage: \_\_\_\_\_

Face Amount: \_\_\_\_\_

\_\_\_ Term 10 15 20 30

\_\_\_ UL

1. When was Scleroderma first diagnosed? \_\_\_\_\_

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

\_\_\_ Skin discoloration

\_\_\_ CREST Syndrome

\_\_\_ Reynaud's Syndrome

\_\_\_ Telangiectasias

\_\_\_ Itching

\_\_\_ Fatigue

\_\_\_ Curling of the fingers

\_\_\_ Muscle weakness

\_\_\_ Digestive Problems

\_\_\_ Gradual tightening and thickening of the skin

\_\_\_ Swelling, stiffness, or pain in the fingers, toes, hands, feet or face

\_\_\_ Ulcers or sores on fingertips, knuckles or elbows

\_\_\_ Shortness of breath, possibly from heart or lung damage

\_\_\_ Brittle bones that may easily break

\_\_\_ Loss of the skin's ability to stretch

\_\_\_ Tingling, numbness, or puffiness

3. Is the proposed insured now, or have they in the past received any of the following treatments:

\_\_\_ Topical Agents

Date(s): \_\_\_\_\_

\_\_\_ Light Therapy

Date(s): \_\_\_\_\_

\_\_\_ Vasodilators

Date(s): \_\_\_\_\_

\_\_\_ D-penicillamine

Date(s): \_\_\_\_\_

\_\_\_ Methotrexate or Cyclophosphamide

Date(s): \_\_\_\_\_

\_\_\_ Other (Describe:) \_\_\_\_\_

4. Is the proposed insured currently taking any medication for this condition, or any other?

\_\_\_ Yes \_\_\_ No (If yes, please provide name, dosage, and frequency)

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