



## Takayasu's Arteritis Questionnaire

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

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: M/F

Tobacco Usage: \_\_\_\_\_ Face Amount: \_\_\_\_\_

\_\_\_Term 10 15 20 30 \_\_\_UL

1. When was the proposed insured diagnosed? \_\_\_\_\_

2. Has the proposed insured experience any of the following symptoms: (Check all that apply)

\_\_\_ Fevers                      \_\_\_ Swollen Glands                      \_\_\_ Anemia  
\_\_\_ Muscle Aches                      \_\_\_ Arthritis                      \_\_\_ Fatigue  
\_\_\_ Abdominal Pain

3. Has the proposed insured had any of the following? (Check all that apply)

\_\_\_ Hypertension                      (What is your average reading) \_\_\_\_\_  
\_\_\_ Stroke                      Details: \_\_\_\_\_  
\_\_\_ Heart Attack                      Details: \_\_\_\_\_

4. How (has/is) the proposed insured being treated? (Check all that apply)

\_\_\_ Steroids (Please provide name, dosage, and frequency:) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Chemotherapy Medications (Please provide frequency and dates administered)  
\_\_\_\_\_

5. Is the proposed insured taking medication for any other health conditions? \_\_\_ Yes \_\_\_ No  
(If yes, please provide name, dosage, and frequency):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_