



Wegener's Granulomatosis 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. Does the proposed insured experience any of the following symptoms: (Check all that apply)

___Upper respiratory symptoms ___Joint Pains ___Weakness ___Skin Lesions
___Fever ___Night sweats ___Conjunctivitis ___Scleritis
___Episcleritis ___Other _____

3. Have any of the following been affected by this condition: (Check all that apply).

___Lungs ___Kidneys ___Musculoskeletal System ___Eyes ___Skin

4. Is the proposed insured currently receiving, or has received in the past, any of the following treatments? (Check all that apply)

___Prednisone ___Cyclophosphamide ___Azathioprine
___Methotrexate ___Bactrim or Septra ___Leucovorin

Details: _____

5. Is, the proposed insured, disabled as a result of this condition? ___Yes ___No
(If yes, please provide the date of disability, disability income source, and amount):

6. Is the proposed insured taking medication for this condition or any other? ___Yes ___No
(If yes, please provide name, dosage, and frequency): _____

