

Glomerulonephritis Questionnaire



Submit This Form with your application for better informed underwriting

Client Information

| | | | | | |
|---|---------------|---------------------|---------------|-----------------------|--|
| Client Name: | | | | | |
| DOB: | Gender | Height | Weight | Marital Status | |
| Occupation & Length of Employment: | | | | | |
| Tobacco Use | Never Used | Totally Stopped | | Current User | |
| | | Date Stopped | | Type Used | |
| Type of Coverage | Term | UL | Survivor | Amount \$ | |

Essential Information

| | | | | |
|---|---|---|--|--|
| 1 | Date of first Diagnosis | | Please note type of Glomerulonephritis | |
| 2 | Was a Kidney Biopsy done? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, give date and diagnosis. | |
| 3 | List current medications (accurate name, dosage and reason) | | | |
| 4 | Please provide the client's most recent readings for the following: | Blood Pressure | | |
| | | BUN | | |
| | | Creatinine | | |
| | | Urinalysis | | |
| 5 | Does the client have any other health issues | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes provide details: | |

Confidential

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