

Polycystic Kidney Disease 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	Do any other family member have ADPKD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, give details</i>
2	Was ADPKD diagnosed by ultrasound?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	What are your current blood pressure readings		
4	Please provide results and date of your most recent urinalysis	Protein	
		Red Blood Cell (RBC)	
		White Blood Cell (WBC)	
		Protein/creatinine ratio	
5	Please provide date and results of the most recent kidney function test	BUN	
		Serum Creatinine	
6	List current medications (accurate name, dosage and reason)		
7	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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