Sarcoidosis 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**		**Was a biopsy done?**	☐ Yes ☐ No
2	**Stage**		**How was the sarcoid treated?**	☐ no treatment ☐ prednisone
3	**Date treatment was completed**			
4	**List current medications (accurate name, dosage and reason)**			

5	**What organs were involved? (check all that apply)**	☐ lung	☐ liver or spleen	☐ kidney	☐ eyes
		☐ heart	☐ central nervous system	☐ lymph nodes	☐ skin

6	**Give results of most recent pulmonary function test**	FVC
		FEVI

7	**Has there been any evidence of recurrence/progression**	☐ Yes ☐ No	*If yes give details:*
8	**Does the client have any other health issues**	☐ Yes ☐ No	*If yes provide details*:

Don Boozer & Associates
P: 1-800-543-0886
F: 1-888-543-0886