Scleroderma / Crest 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**		**Type of Scleroderma**	☐ localized scleroderma – morphea or linea	
				☐ limited scleroderma / CREST	
				☐ progressive systemic sclerosis-diffuse scleroderma	
2	**Please check if the client has had any of the following:**	☐ weight loss	☐ lung disease	☐ biliary cirrhosis	☐ Reyaud's disease
		☐ heart disease	☐ kidney disease	☐ trouble swallowing	☐ Liver enzyme abnormality
3	**List current medications (accurate name, dosage and reason)**				
4	**Please list functional ability**	☐ fully active		☐ uses walker, cane, etc	
		☐ sedentary		☐ uses wheelchair	
5	**Does the client have any other health issues**	☐ Yes ☐ No	*If yes provide details:*		