

# KIDNEY DISEASE—POLYCYSTIC KIDNEY DISEASE QUESTIONNAIRE

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Date of Birth: \_\_\_\_\_  
 Face Amount: \_\_\_\_\_ Max. Premium: \$\_\_\_\_\_/year  UL  WL  Term  Survivorship  
 Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_  
 Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...):  Y  N  
 If Yes, please provide details: \_\_\_\_\_  
 When did you last use any form of tobacco: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year) Type used last: \_\_\_\_\_  
 Height: \_\_\_\_ft. \_\_\_\_in. Weight: \_\_\_\_lbs.

(1) *Has the proposed insured been diagnosed with PKD:* Yes  No

(2) *If (1) is yes, please provide date of diagnosis:* \_\_\_\_\_

(3) *Please provide approximate dates and readings of known blood pressure measurements:*

Approximate date(s):	Systolic/Diastolic reading(s):	Approximate date(s):	Systolic/Diastolic reading(s):

(4) *Please advise of the following laboratory findings, if previously (and recently) done by your physician?*

Laboratory findings of:	Date of most recent test:	Level of findings:	Normal reference range:
Protein in the urine (proteinuria):			
Blood in the urine (hematuria):			
Blood urea nitrogen (BUN) level:			
Creatinine level:			

(5) *Does the proposed insured take any medications? If yes, please list:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken

(6) *Is there any known history of cardiovascular impairment?* Yes  No  If yes, please advise what has been diagnosed and when: \_\_\_\_\_

(7) *Is there any known family history relating to kidney/cardiovascular disease? If yes, please describe:*

	Age (if living)	Age (at death)	Cause of death, if deceased:	History of kidney disease?	History of heart disease or circulatory disorder?	History of stroke?
<i>Mother</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Father</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Sister(s)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Brother</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No