SARCOIDOSIS QUESTIONNAIRE			
Agent: Phone	:	Fax:	
Proposed Insured Name:			
(1) Date of initial diagnosis: How was the sarcoidosis diagnosed (e.g. by x-ray)?			
(2) Was the condition staged? If yes, please check the appropriate stage: Stage II Stage III (3) Describe current symptoms, if any:			
(4) Was there (is there) any treatment for the condition? If yes, describe:			
Date of last treatment:			
(5) Has there been any organ involvement? ☐ No ☐ Yes; please of ☐ Lung ☐ Lymph Nodes ☐ Kidney ☐ Eyes ☐ Other:	check <i>all</i> that were (ar		ous System
(6) Has there ever been a recurrence?			
(7) Please provide the results of the most recent pulmonary function tests, if available: FVC FEV1 (8) Are there any other medical conditions or factors that may be relevant to assessment of the insurability of the individual? If yes:			
(9) Does the proposed insured take any medications or have any been taken in the past to treat the sarcoidosis? If yes, please list: Name of Medication (Prescription or Otherwise) Dates used Quantity Taken Frequency Taken			