Parkinson's Disease Questionnaire

***Agent:*___________________________ *Phone:*_____________ *Fax:*________________**
Client:*___________________________ *DOB :*_______________ ☐ *Male* ☐ *Female
***Product/Face Amount:*___________________________ *Height:*________ *Weight:*___________**

✹ **TOBACCO/NICOTINE USE (*past or present*):** ☐ **YES***** ☐ **NO**
****Please provide details as to any past or present use of tobacco or nicotine products, including type of use, duration & frequency of use, date quit, etc.:*

✹**Date and circumstances surrounding initial Pakinson's diagnosis:**

✹**Please describe current symptoms:**

✹**Is the proposed insured independent (living alone with out assistance)? If no, list the extent of the disability.**

✹**Is the proposed insured receiving any disability payment due to inability to work full time? If so, for how long?**

✹**Is the proposed insured participating in any kind of experimental treatment program? If so, please describe.**_

✹ **FAMILY HISTORY:** (*Family history may be a factor in determining rate class*) **Is there a family history (*parent or siblings*) of the following conditions/disease onset prior to age 60:**

Cardiac Disease	☐ **YES** ☐ **NO**	***Diabetes***	☐ **YES** ☐ **NO**
Stroke or TIA	☐ **YES** ☐ **NO**	***Cancer***	☐ **YES** ☐ **NO**

Please provide details for any "YES" response below (attach additional sheet if necessary)

FAMILIAL RELATIONSHIP	SPECIFIC CONDITION(S)	AGE WHEN DIAGNOSED	CURRENT AGE (*if living*)	DECEASED (*list age @ time of death*)
FATHER				
MOTHER				
SIBLING 1				
SIBLING 2				

✷ **MEDICATIONS -** *List ALL current medications, prescription and non-prescription (including vitamins, nutritional supplements, herbal preparations, etc) in the space provided below:*

MEDICATION	DOSE	MEDICATION	DOSE
1.		***5.***	
2.		***6.***	
3.		***7.***	
4.		***8.***	

✷ **Do you have any other significant health issues or medical conditions not outlined or mentioned on this form?** (*Complete additional questionnaires, as indicated*)

☐ ***Condition(s) - List treatment and current status:***

☐ **NONE -** ***NO other medical conditions or health issues.***

✷ **Have you been previously declined, postponed or rated for life coverage? If so, please outline the circumstances in detail. Include date, insurance company name, reason for decision, as provided by the carrier and the nature of any prior application/submission (formal application vs. informal/trial submission), etc.**

✷**Are there *any* other health factors, circumstances or information you consider to be important in evaluating you as an applicant for life insurance?**