



## Renal 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 of initial diagnosis of kidney disease:**

\* **Specific diagnosis of kidney disorder/disease diagnosed by physician:**

\* **Has dialysis ever been required or proposed?**

\* **Dates and readings obtained via serial blood pressure measurement:**

Date	Systolic/Diastolic	Date	Systolic/Diastolic
1.		5.	
2.		6.	
3.		7.	
4.		8.	

\* **Please provide results of the following laboratory findings, preferably recently performed. If unknown, please attempt to obtain data prior to submission. If actual lab report is available, please attach a copy.**

KEY LAB TESTS	DATE OF TEST	TEST RESULT	REFERENCE RANGE
<i>Urine Protein</i>			0-30 mg/dl
<i>Hematuria (blood in urine)</i>			0 Per HPF/negative
<i>Serum BUN (blood test)</i>			8-25 mg/dl
<i>Serum Creatinine (blood test)</i>			0.6 – 1.3 mg/dl

\* **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.	

\* **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				

\* **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?**