POLYCYSTIC KIDNEY DISEASE

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Do any other family members have ADPKD? ☐ No ☐ Yes; please give details

_____

_____

2. Was ADPKD diagnosed by ultrasound? ☐ No ☐ Yes

3. What are your current blood pressure readings? ☐ No ☐ Yes

4. Please provide the results and date of your most recent urinalysis.

Protein _____

Red blood cell (RBC) _____

White blood cell (WBC) _____

Protein/creatinine ratio _____

5. Please provide the date and results of the most recent kidney function tests.

BUN Date: _____ _____

Serum Creatinine Date: _____ _____

6. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

7. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

