

PROTEINURIA (PROTEIN IN URINE)

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. How long has this abnormality been present? _____ years
 2. Has a specific cause for the proteinuria been found? No Yes; please give details

3. Give the date and results of the most recent urinalysis:
 a. Protein Date: _____
 b. Red blood cells (RBCs) Date: _____
 c. White blood cells (WBCs) Date: _____
 d. Protein/creatinine ratio Date: _____

4. Give the dates and results of the most recent kidney function tests:
 a. BUN Date: _____
 b. Serum creatinine Date: _____

5. If any of the following urinary tests have been completed, give the date and result:
 a. Microalbumin Date: _____
 b. 24-hr. protein Date: _____
 c. 24-hr. creatinine clearance Date: _____
 d. Other: _____ 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

