ARTHRITIS

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:** _____ **Term length:** _____

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. What type of arthritis ? (Example: rheumatoid, osteo, gouty, etc.): _____ Severity (include DAS 28 score if known): _____

2. When was it initially diagnosed? _____

3. Are the joints involved? ☐ No ☐ Yes; Details (type/total #): _____

   Is there evidence of bone erosion on imaging: __ No __ Yes

4. What is the type of treatment, and does it include cortisone/steroids?

   _____

   _____

5. When was the last flare: _____

6. Any assistive devices required (e.g., cane, walker, etc.): ___ No ___ Yes; Details: _____

7. Any other associated complications (e.g., eye problems, vasculitis, rheumatoid nodules, lung disease, unintentional weight loss, osteoporosis, etc.): ___ No ___ Yes: Details: _____

   _____

8. For rheumatoid arthritis:
   Rheumatoid factor: ___ Positive ___ Negative
   Anti-CCP Antibody: ___ Positive ___ Negative
   CRP: _____ Date: _____
   ESR: _____ Date: _____
   Duration of morning stiffness: _____ (hours)
   Albumin: _____ Date: _____
   CBC (Hgb, Hct, Plts, WBC): Date: _____
   ___ Normal ___ Abnormal;
   Details: _____

9. Please list current medications, (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

