

SARCOIDOSIS

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 Type of Coverage: 🗆 Term 🗔 UL 🗔 Survivor UL				
Coverage Amount: Anticipated Premium:				
FAMILY HISTORY Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 Amou	int	Year Issued	Is Policy to be Replaced?
1. Date of first diagnosis:				
2. Was a biopsy done? 🗌 No 🗋 Yes				
3. Stage:				
4. How was the sarcoid treated? No treatment Prednisone				
5. Date treatment was completed:				
6. What organs were involved? (check all that apply) □ Lung □ Kidney□ Heart □ Central nervous system □ Liver or spleen □ Skin □ Eyes □ Lymph nodes				
8. Give results of the most recent pulmonary function tests:				
FVC				
FEV1				
9. Has there been any evidence of recurrence/progression?				
10. Is client taking any medication, including inhalers? (accurate name, dosage, and reason)				
(Accurate) Name of Medication		Dosage	Reason	