



# 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 **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 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