HERMANN SONS LIFE

Hypothyroidism Questionnaire

Name _____ **Date of Birth** _____

1. Have you ever been diagnosed with Hypothyroidism? ☐ **Yes** ☐ **No** If yes, when? _____
2. What type of Hypothyroidism do you have? _____

   _____

   _____

3. Please list all physicians that have treated you for your condition: (Provide names and addresses) _____

   _____

   _____

   _____

4. Do you get your Thyroid Function Test done often? _____ If yes, how often? _____
   Provide the date and the results of your last TSH levels? _____

5. Have you ever received treatment or medications for Hypothyroidism? ☐ **Yes** ☐ **No**
   (If yes, please provide details, including medications taken and when last used) _____

   _____

   _____

   _____

6. Have you ever been hospitalized or seen in the emergency room due to your condition? ☐ **Yes** ☐ **No**
   (If yes, provide dates, names and addresses for all treatment locations) _____

   _____

   _____

   _____

7. Are you experiencing any symptoms associated with your hypothyroidism such as:

☐ poor muscle tone	☐ irritability	☐ low blood pressure	☐ anemia
☐ fatigue	☐ osteoporosis	☐ edema	☐ shortness of breath
☐ cold intolerance	☐ weight loss/gain	☐ joint pain	☐ other
☐ depression	☐ bradycardia	☐ mental confusion	

   Provide details about type of symptoms, severity of symptoms and any treatments:_____

   _____

   _____

   _____

Hypothyroidism Questionnaire continued

Name_____ **Date of Birth**_____

8. Have ever had time off work or had your job duties changed due to Hypothyroidism? ☐ **Yes** ☐ **No**

   (If yes, provide details)_____

   _____

   _____

   _____

9. Please provide any additional information you feel is important concerning your Hypothyroidism. _____

   _____

   _____

   _____

I understand that this declaration will be relied upon by the Company in determining my insurability. I understand that any material misstatement in this declaration, or elsewhere could render the policy, if issued, voidable. I declare that the above answers are true and complete to the best of my knowledge.

_____ _____

Signature of Proposed Insured or Parent/Guardian Date