

**GOUT QUESTIONNAIRE
(COMPLETE ALL QUESTIONS)**

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Date diagnosed or date of first symptoms: _____

2. Number of attacks in the last year? _____

3. Date of last attack? _____

4. Give details of past and current treatment: _____

| 5. Name of Medication: | Dosage: | Frequency (ie., daily, as needed) |
|------------------------|---------|-----------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

6. Do you have any history of:

| | | |
|-------------------------------------|---------|--------|
| Hypertension (high blood pressure) | ___ Yes | ___ No |
| Kidney disease / Kidney Stones | ___ Yes | ___ No |

Explain any "yes" answers and provide date(s) of treatment: _____

7. Name and address of treating physician: _____

8. Date last seen? _____

9. What is your current height? _____ and weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date