



**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

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