

## HEMOCHROMATOSIS QUESTIONNAIRE

Agent: _____	Phone: _____	Fax: _____
Proposed Insured Name: _____ <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth: _____		
Face Amount: _____ Max. Premium: \$ _____/year <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> Term <input type="checkbox"/> Survivorship		
Do you currently smoke cigarettes? <input type="checkbox"/> Y <input type="checkbox"/> N If no, did you ever smoke: <input type="checkbox"/> Never <input type="checkbox"/> Quit (Date): _____		
Do you currently use any other tobacco products (e.g. cigars, pipe, snuff, nicotine patch, Nicorette gum...): <input type="checkbox"/> Y <input type="checkbox"/> N		
If Yes, please provide details: _____		
When did you last use any form of tobacco: _____ (Month) _____ (Year) Type used last: _____		

(1) *When was the condition first diagnosed?* \_\_\_\_\_

(2) *What lead to the diagnosis of hemochromatosis?* \_\_\_\_\_

\_\_\_\_\_

(3) *When you were first diagnosed, how many blood draws (phlebotomies, venesections) were done in what time frame?* \_\_\_\_\_

\_\_\_\_\_

(4) *Are you now on a regular blood draw schedule? If yes, how often do you go? If no, why not?* \_\_\_\_\_

\_\_\_\_\_

(5) *How often do you go for a health check up to your health care provider?* \_\_\_\_\_

(6) *Are your liver function tests normal? Please check with your health care provider if you do not know and list any recent abnormal levels in the following table. These values are important for us to help you get a realistic idea of premiums before completing a formal application of insurance for a specific company:*

*Date of most recent test:* \_\_\_\_\_  *I was told all of my liver function tests were normal.*

*Test values were as follows:* GGTP: \_\_\_\_\_ SGOT/AST: \_\_\_\_\_ SGPT/ALT: \_\_\_\_\_

(7) *Have there been any abnormalities or affects on other organs or tissues? If yes, please describe:* \_\_\_\_\_

\_\_\_\_\_

(8) *Is the proposed insured aware of any medical problems? If so, please describe:*

\_\_\_\_\_

\_\_\_\_\_

(9) *Please list all current medications:*

Name of Medication (Prescription or Otherwise)	Dates used	Quantity Taken	Frequency Taken