

CANCER—CERVICAL CANCER 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: _____		
Height: _____ ft. _____ in. Weight: _____ lbs.		

(1) a) Please provide date of diagnosis: _____ b) Please provide date of last treatment: _____

(2) What was the Stage of the cancer diagnosed (this information should be contained in the pathology report)?

- IA IB IIA IIB III IVA VIBB
 Other staging method used: _____

(3) If the cancer was graded, what grade was assigned?

- I II III IV Other grading method used: _____

(4) How has the cancer been treated?

- Surgery: type of surgery and list what was removed: _____
 Radiation Chemotherapy Biological Therapy Hormone Therapy
 Other: _____

(5) What is the current frequency for checkups? _____

(6) a) Approximate date of most recent Pap smear? _____ b) Approximate date of most recent full pelvic exam? _____

(7) Please describe any recurrence or other cancer that may have occurred: _____

(8) Has the proposed insured taken any medications to treat the cancer in the past and/or is he currently taking any medications?

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

(9) Does the proposed insured have any other medical conditions? If yes, please describe:
