

CANCER QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height _____ Weight _____ Cigarette Smoker: Yes No Quantity per day: _____

1. Type of cancer:

- Bladder
- Breast
- Cervical
- Colon or rectal
- Melanoma
- Prostate
- Skin
- Other _____

2. Date diagnosed (month & year) _____

3. Stage of cancer:

- 1 2 2a 2b 2c 3 3a 3b 4

4. Please check all treatment(s) received and date completed (month & year):

- Surgery _____
- Chemotherapy _____
- Radiation _____
- Hormone _____
- Other (please specify) _____

5. Has there been any evidence of recurring cancer? Yes No

If yes, month & year _____ Location _____

6. Please list all medication currently being taken: _____

7. If colon or rectal cancer: Dukes scale A B1 B2-3 C1 C2 D

8. If melanoma: Clarks level I II III IV V

Location of melanoma and depth : _____

9. If prostate cancer, what was most recent PSA test result? _____

Gleason's Grade 2-5 6 7 8-10

Name of physician with cancer records and date last seen: _____

Address: _____

Notes/comments: _____

Signature of Proposed Insured: _____ Date: _____

Witnessed by: _____