

## **LEUKEMIA QUESTIONNAIRE**

**CLIENT:** NAME \_\_\_\_\_ /  M  F / DOB \_\_\_\_\_ AGE \_\_\_\_\_ / HT \_\_\_\_\_ WT \_\_\_\_\_ / STATE \_\_\_\_\_

AMT. REQUESTED \$ \_\_\_\_\_ / MAX. ANNUAL PREMIUM \$ \_\_\_\_\_ / TYPE OF INS.  UL  TERM YRS. LVL \_\_\_\_\_

TOBACCO USE  NO  YES, TYPE \_\_\_\_\_ / REPLACEMENT  YES  NO / CURRENT ANN. PREM. \$ \_\_\_\_\_

LAST LIFE INSURANCE APP. YEAR \_\_\_\_\_ COMPANY \_\_\_\_\_ ACTION \_\_\_\_\_

OCCUPATION \_\_\_\_\_ / MARITAL STATUS  SINGLE  MARRIED  WIDOWED  DIVORCED

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ SIBLING 1 \_\_\_\_\_ SIBLING 2 \_\_\_\_\_ SIBLING 3 \_\_\_\_\_

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH \_\_\_\_\_

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS \_\_\_\_\_ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS \_\_\_\_\_

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK?  NO  YES, DETAILS \_\_\_\_\_

DATE OF LAST MEDICAL CHECKUP \_\_\_\_\_ / DATE OF LAST EKG \_\_\_\_\_ AND RESULTS \_\_\_\_\_

LAST BLOOD PRESSURE READING (RESULTS) \_\_\_\_\_ / \_\_\_\_\_ / ARE YOU TREATED FOR BLOOD PRESSURE  NO  YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) \_\_\_\_\_, \_\_\_\_\_ TREATED FOR CHOLESTEROL  NO  YES

**AGENT:** NAME \_\_\_\_\_ PHONE \_\_\_\_\_ FAX \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

1. PLEASE LIST DATE OF FIRST DIAGNOSIS \_\_\_\_\_

2. PLEASE INDICATE TYPE:

- ACUTE GRAULOCYTIC (AGL)  
 ACUTE LYMPHOBLASTIC (ALL)  
 ACUTE LYMPHOCYTIC (ALL)  
 ACUTE NON-LYMPHOBLASTIC (ANLL)  
 HAIRY CELL (HCL)  
 OTHER \_\_\_\_\_

3. PLEASE INDICATE STAGE:

- STAGE 0  
 STAGE 1  
 STAGE 2  
 STAGE 3  
 STAGE 4

4. IS CLIENT CURRENTLY IN REMISSION?  NO  YES

IF YES, LIST DATE REMISSION STARTED \_\_\_\_\_

5. IS CLIENT ON ANY MEDICATIONS FOR THIS DISEASE?

- NO  YES, DETAIL TYPE(S) AND DOSAGE(S):  
 \_\_\_\_\_

6. PROVIDE RESULTS OF MOST RECENT CBC (COMPLETE BLOOD COUNT):

DATE \_\_\_\_\_

HEMOGLOBIN \_\_\_\_\_

WHITE BLOOD CELL COUNT \_\_\_\_\_

PLATELET COUNT \_\_\_\_\_

7. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY):  
 \_\_\_\_\_  
 \_\_\_\_\_