

## **HEPATITIS (Elevated Liver Functions) 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 AND RESULTS OF CLIENT'S TWO MOST RECENT LIVER FUNCTION TESTS:

	RESULT	DATE#1	RESULT	DATE#2
AST/SGOT	_____	_____	_____	_____
ALT/SGPT	_____	_____	_____	_____
GGTP	_____	_____	_____	_____
ALK PHOS	_____	_____	_____	_____
BILIRUBIN	_____	_____	_____	_____

2. CHECK TYPE, AND LIST DATE AND RESULTS OF RECENT HEPATITIS SCREENING:

A DATE \_\_\_\_\_  NEG  POS  
 B DATE \_\_\_\_\_  NEG  POS  
 C DATE \_\_\_\_\_  NEG  POS

3. HAS THE CLIENT HAD A LIVER BIOPSY?

NO  YES, DETAIL DATE AND RESULTS \_\_\_\_\_

4. HAS THE CLIENT EVER BEEN DIAGNOSED WITH (CHECK

AND DETAIL ANY/ALL THAT APPLY):

FATTY LIVER, DETAILS \_\_\_\_\_

HEPATITIS, TYPE:

ACUTE  CHRONIC ACTIVE  CHRONIC PERSISTENT

DETAILS \_\_\_\_\_

CIRRHOSIS, DETAILS \_\_\_\_\_

5. DOES THE CLIENT CONSUME ANY TYPE OF ALCOHOLIC BEVERAGE?

NO  YES, DETAIL FREQUENCY AND AMOUNT:

IF NO, DATE OF LAST DRINK: MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

6. DATE OF CLIENT'S LAST VISIT TO A PHYSICIAN:

0 TO 6 MONTHS AGO  
 6 TO 12 MONTHS AGO  
 12 TO 24 MONTHS AGO  
 OVER 2 YEARS AGO

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