



MEDICAL HISTORY QUESTIONNAIRE: OVARIAN CANCER

Client Name: _____ Date of Birth: _____

Gender: Male Female Height: _____ Weight: _____

Tobacco Usage: Never Former Current
 Date Stopped: _____ Type: _____

Coverage Information: Type: Term UL IUL
 WL VUL Survivorship
 Face Amount: _____
 Premium Tolerance: _____

Proposed Insured's Existing Insurance			
Insurance Company	Face Amount	Year Issued	Replacement (Yes/No)

1. Date of Diagnosis _____

2. What stage was the cancer?

I II III IV

3. How was the cancer treated? (check all that apply)

Surgery Radiation Therapy Chemotherapy

4. Date treatment was completed: _____

5. Has there been any evidence of recurrence? No Yes

If yes, please provide details: _____

6. Please give the date and result of the most recent CA 125, if available: _____

7. Please list current medications

Name of Medication	Dosage	Reason

8. Are there any other health issues? (Additional Questionnaires may be required) No Yes

If yes, please provide details: _____

