



MEDICAL HISTORY QUESTIONNAIRE: TESTICULAR 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 was the type of testicular cancer? Seminoma Non-seminoma

3. What stage was the cancer? I II III

4. How was the cancer treated? (check all that apply)
 Surgery Chemotherapy Radiation therapy

5. Date treatment was completed: _____

6. Has there been any evidence of recurrence? No Yes
 If yes, please provide details: _____

7. Please give the date and result of the most recent AFP or HGC test: _____

8. Is there a family history of cancer? No Yes
 If yes, please provide details: _____

9. Please list current medications

Name of Medication	Dosage	Reason

10. Are there any other health issues? (Additional Questionnaires may be required) No Yes
 If yes, please provide details: _____