Brain Tumor Questionnaire

Independent financial services professional name (print) ______ phone ______ e-mail ______

insurance product desired ______ benefit (amount) ______ riders desired ______

insured's name (print) ______ resident state ______ application state ______

___/___/___ birth date | M or F gender | ___ ft. ___ in. height | ___ lbs. weight

1) Have you used any of the following tobacco/nicotine products during the past five years?

Yes	No	
○	○	**Chew** - If Yes, current usage amount ______ last date used ______
○	○	**Cigarettes** - If Yes, current usage amount ______ last date used ______
○	○	**Cigars** - If Yes, current usage amount ______ last date used ______
○	○	**Pipe** - If Yes, current usage amount ______ last date used ______
○	○	**Products To Aid in Quitting** - If Yes, list products, current usage amount and last date used, below:

2) When was your tumor first detected? ___/___/___

3) What prompted you to visit a doctor that led to the detection?

4) Did you have surgery to remove the tumor? ○Yes ○No

If Yes provide date of surgery, amount (%) of tumor removed, size of tumor, stage and grade of tumor, name or type of tumor and if any complications occurred during or after surgery. If No, please tell us why it was not removed surgically.

Type of Tumor:

Size of Tumor:

5) Have you had any additional surgeries for recurrence, cyst drainage, shunt placement or necrosis removal? ○Yes ○No

If Yes provide date of surgery, complete details and if any complications occurred during or after surgery.

6) Have you had radiation therapy? ○Yes ○No

If Yes provide last treatment date, type, dose, number of treatments, duration of treatment regimen and if any complications occurred during or after the treatment.

Brain Tumor Questionnaire continued...

7) Have you had chemotherapy? ○Yes ○No

If Yes provide last treatment date, name of drugs, number of treatments, duration of treatment regimen and if any complications occurred during or after the treatment.

8) Have you had Gamma Knife, Cyber Knife or Stereotactic Radiosurgery? ○Yes ○No

If Yes provide treatment date, type of treatment and if any complications occurred during or after the treatment.

9) Have you participated in any experimental therapies or clinical trials? ○Yes ○No

If Yes provide treatment date, type of treatment and if any complications occurred during or after the treatment.

10) When was your most recent MRI, CT or PET scan?____/____/____

Please list the findings of the scan or scans completed and any recommendations made by your doctor due to the findings of the scan(s).

11) Have you had any other treatments not listed above? ○Yes ○No

If Yes provide treatment date, type of treatment and if any complications occurred during or after the treatment.

12) Have any additional treatments been suggested or recommended? ○ Yes ○ No

If Yes provide scheduled treatment date if any, if none state not scheduled, type of treatment and why recommended.

13) Have any of your family members (i.e. mother, father or siblings) ever had any tumors? ○Yes ○No

If Yes provide details to the best of your knowledge.

Brain Tumor Questionnaire continued...

14) List all medications you are currently taking to include the dosage and the reason for taking them?

15) List any other medical condition you have been diagnosed with that is still present.
Depending on the condition, additional questionnaires may need to be completed.

16) List any other information that may be helpful to us in reviewing your insurance possibilities.
Please be as detailed as possible.