PSA—ELEVATED

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐ Term ☐ UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income: _____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. How long has the PSA been elevated? _____

2. What is the diagnosis? _____

3. Please give the date and result(s) of all recorded PSA value(s): _____

4. Have these results been
☐ Increasing
☐ Decreasing
☐ Stable
☐ Fluctuating up and down
☐ Unknown

5. If any of the following have been done, please give the details including dates completed and result(s):

☐ MRI (Please include PIRADS category)_____

☐ TRUS _____

☐ PSAD _____

☐ Free PSA _____

☐ Prostate biopsy _____

6. When was your last follow up? _____ Are any tests pending/recommended?_____

7. Is client taking any medication? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

8. Are there any other health problems? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

